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# he West Virginia Medical Journal

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*1980 — Year of Opportunity*
*See Page 16*

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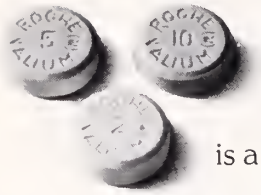
*13th Mid-Winter Clinical Conference*
*January 25-27*

Volume 76 Number 1
January 1980

# A character all its own.




Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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# The West Virginia Medical Journal

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## CONTENTS

**Scientific Articles**

Bone Marrow Aspiration and Biopsy—Peter C. Raich, M. D.; and John S. Rogers II, M. D. 1

Percutaneous Antegrade Pyelography and Nephrostomy Guided by Ultrasound — Morteza E. Elyaderani, M. D.; and Stanley J. Kandzari, M. D. 5

Metastatic Melanoma to the Bladder — Gregory J. Post, M. D.; and Bradford M. McCuskey, M. D. 7

**Scientific Department**

Medical Grand Rounds From the West Virginia University Hospital (Testicular Carcinoma)—Edited by Irma H. Ullrich, M. D. 9

**The President's Page**

A Year of Opportunity—Stephen D. Ward, M. D., President, W. Va. State Medical Association 16

**Editorials**

VE and You 17

Paradox 17

Trouble With FOIA 18

Ethical Challenge 18

**General News**

13th Mid-Winter Clinical Conference 19

MMIS, Uniform Claim Forms Scheduled 22

Fall Meeting of Council 22

Plans Approved for Association 'Home' 23

Doctor Blaydes Honored by Eye Academy 24

Urology Lectureship Honors Doctor Hoffman 25

Eight Hospitals Seek Rehab Planning Funds 25

**Special Departments**

WVU Medical Center News x

Third-Party News, Views, Program Concerns xii

Obituaries xiv

County Societies xvii

Classified Section xviii

Index To Advertisers xx



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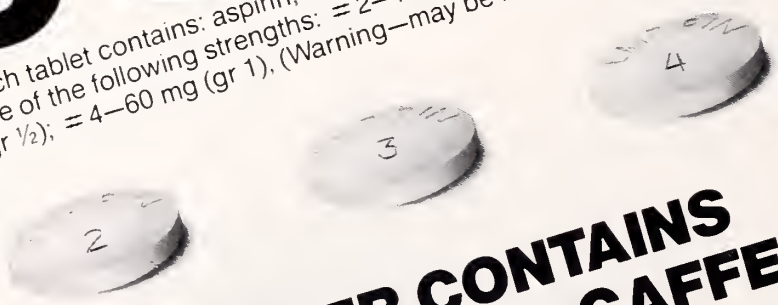


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**Warnings:** Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

**Precautions:** Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

**Adverse Reactions:** Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

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4 mg perphenazine and 10 mg amitriptyline HCl.

**CONTRAINDICATIONS:** Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

**WARNINGS:** TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

**PRECAUTIONS:** Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

**Perphenazine:** Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

**Amitriptyline:** In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

**ADVERSE REACTIONS:** Similar to those reported with either constituent alone.
**Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia, antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect, hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

**Amitriptyline:** Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia, palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia, nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria, photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia, eosinophilia, purpura; thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress; vomiting; anorexia, stomatitis; peculiar taste; diarrhea, parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

**OVERDOSAGE:** All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

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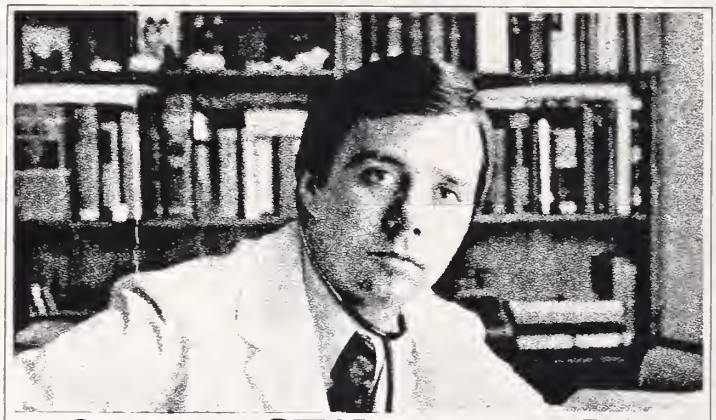

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| Time after drug administration (hour) | | .5 | 1 | 2 | 3 | 4 |
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| Mean relief-of-pain scores* (No. patients reporting) | Motrin 400 mg ibuprofen | .89 (108) | 1.25 (108) | 1.36 (108) | 1.28 (107) | 1.19 (106) |
| | Darvon 65 mg propoxyphene | .66 (100) | .99 (99) | 1.13 (96) | .99 (96) | .80 (96) |
| Statistical significance | | $p<0.02$ | $p<0.01$ | $p<0.05$ | $p<0.02$ | $p<0.002$ |

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

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- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

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**Indications and Usage:** Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

**Adverse Reactions**

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*Causal relationship unknown*

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# Bone Marrow Aspiration And Biopsy

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*Needle bone marrow biopsy has become a valuable addition to bone marrow aspiration in the evaluation of hematological and malignant disorders. Obtaining a marrow biopsy is especially important in those conditions where no aspirate is obtained or where an infiltrative process is suspected. The combined procedure can easily be performed at the bedside with a minimum of preparation, and serious complications are uncommon.*

Bone marrow aspiration and, more recently, marrow biopsy have provided valuable information to physicians evaluating and treating patients with hematologic and malignant disorders. It is important that this procedure be performed correctly, including the collection of a sufficient amount and type of specimen along with the proper processing of the material obtained, in order to obtain the maximum of information. Marrow aspiration and biopsy should be considered a standard procedure in the evaluation of many hematological disorders. The primary clinical indications for performing a bone marrow examination are outlined in Table 1.

At times, even with proper technique, aspiration of marrow is unsuccessful (dry tap). This may be due to infiltration or replacement by tumor, fibrosis or granuloma, or due to an aplastic marrow. In such cases, obtaining a bone marrow biopsy is mandatory. Table 2 outlines those conditions where a marrow biopsy is especially important. Although morphology of individual cells is better visualized on aspiration smears, the biopsy best reflects architectual derangements of the marrow and allows for estimation of the relative distribution of the cellular population. In newly evaluated patients it is usually best to obtain a marrow biopsy along with the aspirate. In the initial staging of malignant lymphomas and metastatic malignancies, bilateral biopsy specimens are recommended, while for most other disorders a single, generous biopsy specimen is usually adequate.

### Site for Procedure

In the adult the greatest concentration of active red marrow is located in the sternum, ribs, vertebral bodies, pelvis, and the upper portion of the humerus and femur (Figure 1). Other sites are less cellular and are frequently replaced by fat. The posterior or anterior iliac crest, and occasionally the spinous processes of the third and fourth lumbar vertebrae, are the most preferred sites for marrow biopsy, mainly because of their accessibility.

In children, red marrow is more widely distributed. In those less than two years old the medial aspect of the proximal tibia is the preferred site. In the 2-to-11 age group either the iliac crest or the tibia may be used.

The amount of pain experienced by the patient during posterior iliac crest biopsy is little different from that during a sternal aspiration. Although the bone cortex tends to be somewhat thicker at the iliac crest, this leads to little difficulty in penetration. In addition, no significant difference in marrow cellularity and composition has been demonstrated between the sternal and iliac crest sites.

The preferred site for biopsy is the posterior superior iliac spine (Figure 2), although the anterior iliac spine may be more easily accessible

in extremely obese individuals. The posterior iliac crest is an oblong, bony protruberance, palpable three to five cm. from the midline and five to seven cm. caudal to the level of the superior margin of the iliac crest. The posterior superior spine forms the most caudal portion of the posterior iliac crest.

The posterior iliac crest site has the added advantage of removing the procedure from the patient's vision. Since no vital structures are in the immediate vicinity of the biopsy site, no serious complication need be anticipated. Infrequently, however, under adverse circumstances, complications may arise following the biopsy procedure. Two cases of retroperitoneal hemorrhage have been reported following posterior iliac crest biopsy performed by inexperienced individuals in patients with advanced osteoporosis and renal osteodystrophy. In contrast, however, over 20 deaths resulting directly from diagnostic sternal puncture have been reported while no fatalities were attributable to iliac crest puncture. Among 1,598 iliac crest biopsies reported in one series, infection occurred at only two biopsy sites.

### Marrow Biopsy Needle

Bone marrow needle biopsy was first made feasible by McFarland and Dameshek who, in 1950, reported a procedure using the Vim-Silverman needle. In 1964, Ellis, Jensen and Westerman reported their modification of the biopsy needle, the Westerman-Jensen needle.* More recently, another biopsy needle design has been introduced, the Jamshidi needle,** which cuts the biopsy core with the sharp cutting edge of the hollow needle and retains the biopsy core inside due to the tapered construction of the needle. The relative ease with which a non-crushed specimen is obtained with the Jamshidi needle makes it the favorite needle in present

*Becton, DicKinson & Co., Rutherford, N. J.
**Kor-Med Corporation, Minneapolis, Minn.

**TABLE 1**

**Clinical Indications for Marrow Aspiration and Biopsy**

1. Anemia—Especially those due to decreased or ineffective erythropoiesis, including iron deficiency and megaloblastic anemia.
2. Cytopenia—Including aplastic anemia, neutropenia and thrombocytopenia.
3. Hematologic malignancies—Including acute and chronic leukemias, myeloproliferative disorders, multiple myeloma and Waldenstrom's macroglobulinemia.
4. Metastatic malignancy—solid tumors and malignant lymphoma when marrow involvement is suspect.

**TABLE 2**

**Indications for Bone Marrow Biopsy**

1. Any "dry tap" (unsuccessful aspirate).
2. Myeloproliferative syndromes including polycythemia vera, myelofibrosis and primary thrombocythemia.
3. Evaluation and staging of Hodgkin's disease and other malignant lymphomas.
4. Metastatic tumor.
5. Aplastic and hypoplastic anemias.
6. Acute leukemia during period of intensive chemotherapy (marrow hypoplasia).
7. Thrombotic thrombocytopenic purpura.
8. Disseminated granulomas (military tuberculosis, sarcoidosis, fungal), amyloidosis.
9. Metabolic bone disease (osteitis fibrosa, Paget's disease).

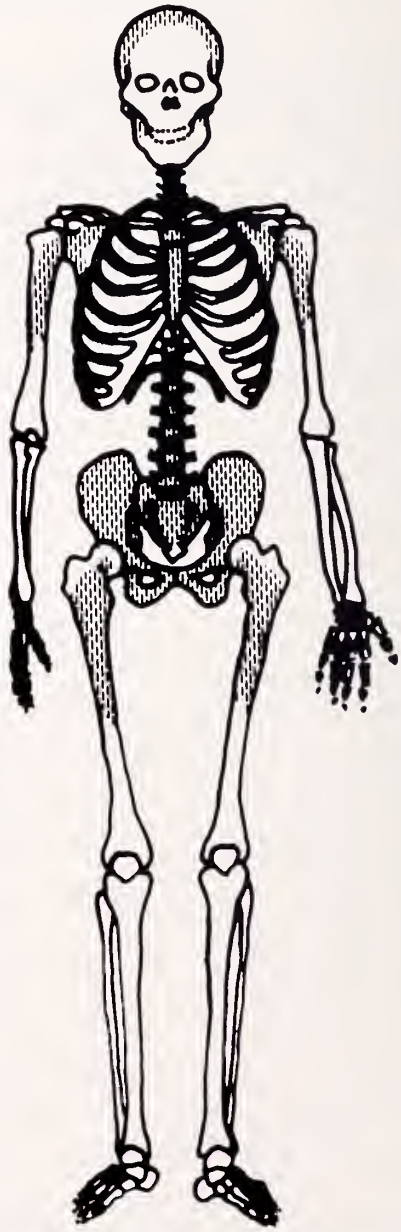

**Figure 1. Anatomical distribution of active bone marrow in the normal adult.**

use. The standard, adult-sized Jamshidi needle (#11) is the preferred biopsy needle for adults and all but very young children.

### Patient Preparation

The procedure can easily be performed at the bedside. An apprehensive patient may be given meperidine I. M. or diazepam I. V. prior to the procedure. The patient is placed either in the prone or the lateral recumbent position, near the edge of the bed or examining table. After routine surgical prepping and draping of the area, the skin, subcutaneous tissue and periosteum are infiltrated with one per cent lidocaine or a similar local anesthetic. The skin and the periosteum are the most sensitive areas and should be anesthetized adequately. In some obese patients it may be necessary to outline the position and configuration of the posterior iliac spine by probing with the long, No. 22-guage needle used for infiltrating. The site should be changed if no bone is encountered beyond a distance of about five to seven cm. After waiting several minutes to allow the local anesthetic to take effect, a small incision is made in the skin with a sharp, pointed blade to allow for easier penetration by the biopsy needle.

### Marrow Aspiration

The marrow aspirate specimen may be obtained through the biopsy needle before the biopsy specimen is obtained. The large volume of the biopsy needle may tend to dilute the aspirate specimen, and care should be taken to redirect the biopsy needle away from the site of aspiration to avoid obtaining an artifactually-altered biopsy specimen. It is usually preferred to obtain the marrow aspirate specimen by using a smaller-bore needle either before or after the biopsy. A No. 18 Illinois or No. 16 Vim-Silverman needle is usually selected for the aspiration. Obtaining one ml. of aspirate specimen is usually sufficient, and withdrawal of a larger volume of marrow blood dilutes the specimen. Pain on aspiration indicates that the needle is in the proper location within the marrow cavity. Part of the aspirate specimen is placed in a petri dish or on a slide from which marrow particles may then be selected out, gently compressed between two cover slips and spread in order to allow for optimum morphological detail of individual marrow cells. If clinically indicated, specimens for bacterial and fungal culture and for chromosome studies also may be obtained at this time.

### Marrow Biopsy

The biopsy needle with the stylet locked in place is advanced through the skin, subcutaneous tissue and the periosteum perpendicular to the plane of the back. Once the outer portion of the cortex has been penetrated, the needle is directed about 30 degrees cephalad and 30 degrees laterally (pointing to the anterior iliac spine) in order that the needle will advance within the marrow cavity between the two cortical tables of the flat portion of the ileum (Figure 3). By using a rotary, boring motion and moderate pressure the needle is advanced through the cortex; pounding should not be necessary. After one to two cm.

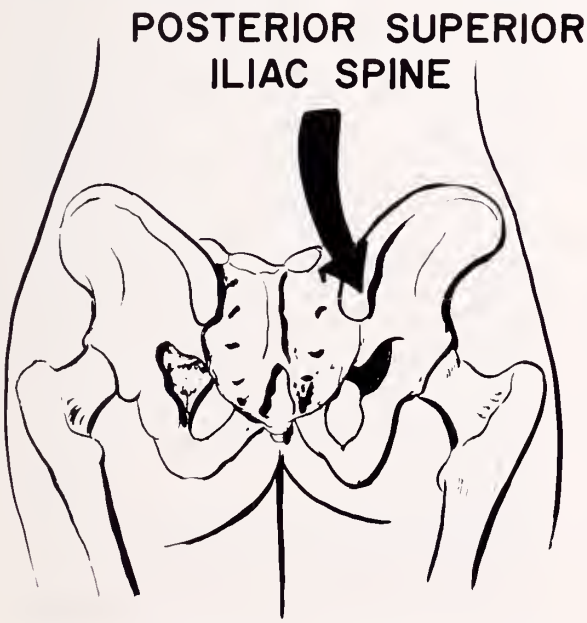


**Figure 2. Location of the posterior iliac spine.**

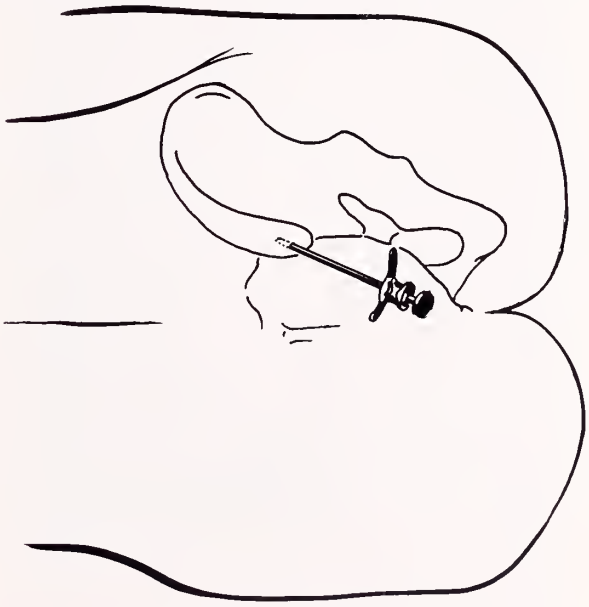

**Figure 3. Position of the needle in the cortex of the posterior iliac crest.**

of penetration, a decrease in resistance will be apparent along with change to a gritty sensation against the tip of the needle, characteristic of the cancellous bone of the marrow cavity. The stylet is then removed, leaving the biopsy needle in place, seated solidly in bone.

With the stylet removed, the Jamshidi biopsy needle is advanced slowly and gently with a clockwise-counterclockwise motion for another two to four cm. The further the needle is advanced within the marrow the better the specimen will be and the less likely it is to slip out while the needle is removed. In order to sever the distal attachment of the specimen within the biopsy needle, it is recommended that the needle be withdrawn two to three mm., then redirected at a slightly different angle and advanced for about five mm. The biopsy needle is then rotated along its axis with quick, full twists several times to the right and to the left, after which the needle is removed slowly from the bone with alternating rotary motion. Rapid withdrawal of the needle tends to produce a suction effect causing the biopsy specimen to slip out of the needle and remain in the marrow cavity. The biopsy specimen is removed by inserting the probe through the distal cutting end of the needle and gently pushing the biopsy specimen out the proximal end of the needle onto a slide or coverslip. Touch imprints are then made from the relatively-dry biopsy core, after which it is placed in the appropriate fixative solution.

If the Westerman-Jensen needle is employed to obtain the biopsy specimen, the inner, split cutting needle has to be advanced a distance of two to three cm. before the outer needle is advanced in rotary fashion over the cutting needle containing the biopsy specimen. The removal of the needle and of the specimen is then identical to the Jamshidi needle. The biopsy specimen is less easily lost with the Westerman-Jensen needle; however, the degree of crushed artifact is usually greater.

An adequate marrow biopsy specimen will consist of a long round core approximately one to three cm. in length and 1.5 to two mm. in diameter. A normal specimen grossly will appear quite red with a spongy network of bony trabeculae which will feel gritty to the touch of a needle. A pale specimen may be seen in marrow aplasia, fibrosis, or invasion with malignant tissue.

In the individual without a bleeding problem postbiopsy care consists of application of local pressure for approximately five minutes. If a bleeding problem exists, pressure should be applied for at least 10 minutes or until the bleeding has stopped. Following this, a pressure dressing is applied and the patient is instructed to remain on his back for about one hour. We have rarely experienced any serious bleeding problems, even in severely thrombocytopenic patients. Local tenderness at the biopsy site may persist for several days; however, analgesics are seldom necessary.

### Handling of the Specimen

A bone marrow examination should include at least those items marked with a star in Table 3. The marrow particles or spicules obtained by aspiration are smeared on either cover slips or glass slides. These preparations are stained with either Wright or Giemsa stain. Another smear is stained with Prussian blue for iron. In patients with acute leukemia special cytochemical stains on the aspirate specimen have been helpful in classifying the leukemic cell type. The clot that remains after the smears are prepared should be fixed in Zenker's or formalin solution for subsequent sectioning. Clot sections of the marrow aspirate are especially useful if an insufficient marrow biopsy is obtained. Both the clot section and the biopsy are useful for evaluating marrow cellularity, but the former is less likely to demonstrate a focal infiltrative process. At the time the marrow biopsy is obtained, touch imprints should be made from it by touching and slightly pushing the biopsy specimen over a coverslip or slide. This step is especially important if no aspirate can be obtained. The marrow biopsy core is then submitted for fixation, sectioning and staining with Wright-Giemsa or H&E stain.

**TABLE 3**

I. Aspirate
- A. Cover slip or glass slide of marrow particles.
  - *1. Wright or Giemsa stain
  - *2. Prussian blue (iron) stain
  - 3. Special cytochemical stains if indicated
  - 4. Chromosome studies (including Philadelphia chromosome) if indicated
  - 5. Electron microscopy if indicated
  - 6. Culture (bacterial, fungal, viral) if indicated
- B. Clot section
  - 1. Wright-Giemsa or H&E (if no biopsy)
  - 2. Iron stain (if no aspirate)

II. Biopsy Core(s)
- *A. Touch preparation or imprint with Wright or Giemsa stains
- *B. Wright-Giemsa or H&E stain of section
- C. Special stains for tuberculosis, fungi, fibrosis, amyloid if indicated

# Percutaneous Antegrade Pyelography And Nephrostomy Guided By Ultrasound

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*Antegrade pyelography was performed in eight patients including one patient who had percutaneous nephrostomy. There were no complications encountered, and the pig-tail catheter was found to be very useful for percutaneous nephrostomy.*

WHENEVER renal function is poor or there is nonvisualization of the kidneys on an intravenous pyelogram, a retrograde pyelogram is performed. In patients where cystoscopic catheterization of the ureters has failed, the kidneys can be visualized by a new technique that requires no regional or general anesthesia.

Percutaneous antegrade pyelography and nephrostomy is a safe and effective method under guidance of ultrasound. Antegrade pyelography has valuable diagnostic information, and percutaneous nephrostomy can provide temporary or permanent therapeutic drainage of the upper urinary tract in patients who are unable to withstand emergency surgery.[7,8]

### Technique and Material

The patient is placed in the prone position. With the guidance of ultrasound, the renal pelvis will be seen as an echo-free area in the anterior and medial aspect of the kidney. In obstructive uropathy there is no problem in visualizing the hydronephrotic collecting system.

Following preparation of the skin and application of local anesthesia, the renal pelvis is punctured by a 22-guage needle with the use of an aspiration transducer which has a central canal for introduction of the needle.[4,5]

Following the removal of 10-20 cc's of urine, the contrast material is injected and radiographs obtained.

If a nephrostomy is to be performed, a 20-guage needle with a teflon sheath over the needle may be used for the initial puncture. The steel needle is withdrawn leaving the teflon sheath within the pelvis. In order to obtain better drainage, the teflon sheath can be replaced by a larger catheter.

This is performed by passing a soft-end, J-shaped guide wire through the teflon sheath and into the renal pelvis under fluoroscopy. The teflon sheath is removed. The dilator, which has a tapered end, is applied over the guide wire to establish a tract into the renal parenchyma. The dilator is removed and a number seven or eight angiographic catheter is introduced over the guide wire into the renal pelvis. We have noticed that a pig-tail-shaped angiographic catheter has more advantages than a straight catheter in that it will not slip out of the kidney. Once the catheter is in satisfactory position, it is sutured to the skin for permanent drainage. Catheter changes are done using successively larger and softer catheters. Once a tract is established, a larger 14 to 18F silastic tube can easily be placed for permanent drainage.

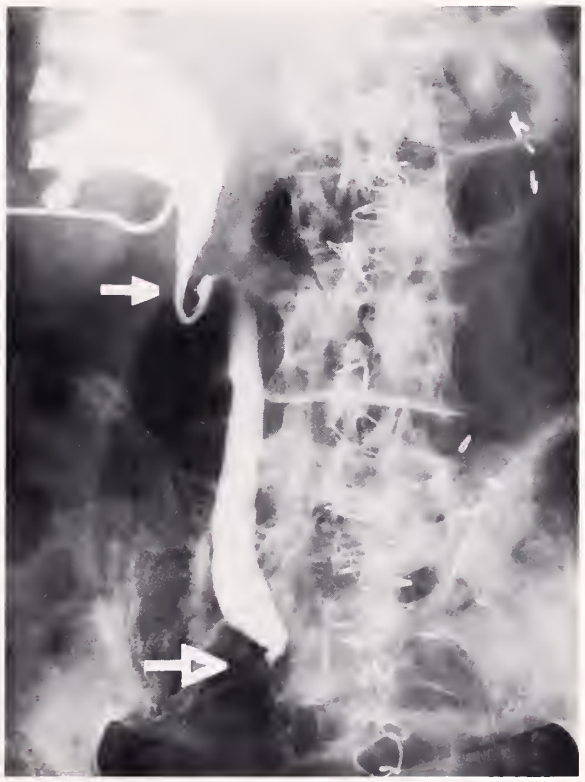

**Figure. Percutaneous nephrostomy in a patient with metastatic carcinoma of colon. Note obstruction in distal ureter by tumor (solid arrow) and tip of pig-tail catheter in ureteropelvic junction (open arrow).**

## Discussion

When retrograde pyelography is unsuccessful or fails to demonstrate the proximal portion of an obstructed ureter, antegrade pyelography can be performed. In patients with an ileal conduit where there is a question of obstruction to the kidney, antegrade pyelography will make the point of obstruction clearly visible whenever a "loop-o-gram" fails to demonstrate reflux.

In a poorly visualized, transplanted kidney, antegrade pyelography will show the collecting system very nicely and is very valuable in demonstrating leakage of urine from the anastomotic site. This technique can also be performed in patients with acute urinary tract infection who are not candidates for retrograde pyelography.[2,3,4] The diagnostic yield is significant. Percutaneous nephrostomy for emergency decompression of the kidney in selected cases can provide a temporary or permanent therapeutic drainage according to the need of the patient (Figure).

We have performed eight cases of antegrade pyelography and one case of percutaneous nephrostomy (Tables 1, 2). In the case where a nephrostomy was performed, the patient improved significantly and later was a candidate for permanent surgery. Antegrade pyelography is restricted to patients in whom transcystoscopic ureteral catheterization has failed. The technique is simple and almost painless. Antegrade pyelography provides medical information that cannot be obtained by other radiographic methods. The authors have experienced no complications with this procedure.

In summary, antegrade pyelography and percutaneous nephrostomy are safe and have great diagnostic and therapeutic yield in selected cases.

**TABLE 1**

**Etiology of Renal Obstruction**

| *Patient* | *Age* | |
|---|---|---|
| A.A. | 63 | Periureteral fibrosis, due to previous surgery |
| E.W. | 50 | Metastatic carcinoma of the colon with bilateral hydronephrosis |
| M.C. | 3 | Ureterovesical stenosis from a ureteral reimplantation |
| A.M. | 57 | Acute and chronic ureteritis |
| Z.M. | 59 | Obstructed pyonephrosis |

**TABLE 2**

**Kidney Transplant Complications**

| *Patient* | *Age* | *Findings by Antegrade Pyelography* |
|---|---|---|
| D.R. | 20 | Leakage at the ureterovesical anastomosis |
| K.F. | 17 | Leakage from lower pole calyx |
| K.F. | 17 | Vesicocutaneous fistula |

## References


1. Barbaric ZL, Thomson KR: Percutaneous nephropyelostomy in the management of obstructed renal transplants. *Radiol* 126:639-642, 1978.

2. Barbaric ZL, Wood BP: Emergency percutaneous nephropyelostomy: Experience with 34 patients and review of the literature. *Am J Roentgenol* 128:453-458, 1977.

3. Burnett LL, Correa Bush WH Jr: A new method for percutaneous nephrostomy. *Radiol* 120:557-561, 1976.

4. Harris RD, McCullough DL, Talner LB: Percutaneous nephrostomy. *J Urol* 115:628-631, 1976.

5. Stubles DP, Holt SA, Cheridan HM, Donohue RE: Permanent nephrostomy via percutaneous puncture. *J Urol* 114:684-687, 1975.

6. Pedersen JF: Percutaneous nephrostomy guided by ultrasound. *J Urol* 112:157-159, 1974.

7. Saxon HM, Ogg CS, Cameron JS: Needle nephrostomy. *Brit Med Bull* 28:210, 1972.

8. Wickom I: Pyelography after direct puncture of renal pelvis. *Acta Radiol* 41:505, 1954.

# Metastatic Melanoma To The Bladder

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*Metastatic melanoma involves the urinary tract much more frequently than is clinically realized. Excretory urography and cystoscopy are valuable diagnostic studies in helping to establish the presence of metastatic disease.*

MALIGNANT melanoma is well-known for its propensity to metastasize widely. Involvement of the genitourinary tract is usually a sign of disseminated disease and indicates a poor prognosis. The use of excretory urography and cystoscopy are useful diagnostic studies to establish the presence of widespread metastases. The following case will illustrate this point.

**Figure 1. Intravenous pyelogram demonstrating a two-cm. polypoid mass arising from left lateral bladder wall.**

**Case Report**

A 64-year-old white female was admitted to Wheeling Hospital for evaluation of gross painless hematuria. Two months prior to admission, she noted multiple small pigmented lumps on her back, left shoulder, and beneath her right breast. Subsequent biopsy of two of these lesions revealed malignant melanoma. Chest x-ray showed multiple pulmonary nodules consistent with metastases. Intense localized uptake in the right eleventh and twelth ribs and upper sternum was noted on nuclear bone scan. Intravenous pyelogram demonstrated normal upper tracts; however, a two-cm. polypoid mass arising from the left lateral wall of the urinary bladder was present on multiple views of the bladder (Figure 1).

Cystoscopic examination showed a discrete, round, two-cm. necrotic tumor mass located on the mid-left lateral wall. Transurethral resection of the tumor was performed. Microscopically, the lesion consisted of closely packed polyhedral cells with hyperchromatic nuclei and pale brownish pink cytoplasm containing fine "dust-like" brown

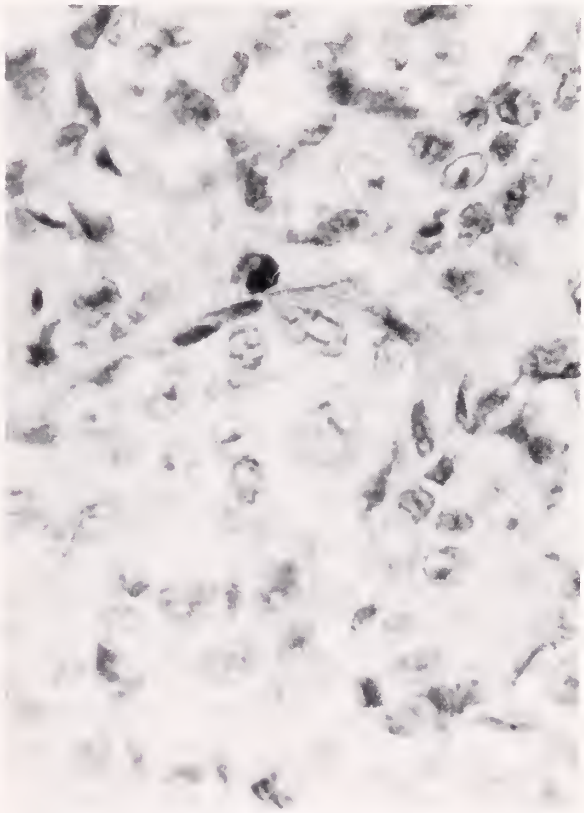

**Figure 2. Microscopic section (250 x) of malignant melanoma involving bladder.**

pigment (Figure 2). The tumor was identical in morphological appearance to the subcutaneous tumor previously removed. The patient was placed on DTIC therapy but has continued to show signs of progressive disease. She was recently readmitted with extensive central nervous system metastases.

### Discussion

Metastatic melanoma to the urinary tract occurs more frequently than was once realized.[1] Goldstein reported 77-per-cent renal involvement and 28-per-cent bladder involvement in 71 patients with disseminated disease.[2] Abeshouse noted that 37 per cent of patients with metastatic melanoma had bladder involvement.[3] Ureteral involvement was much less common with less than 10-per-cent involvement noted in most series of patients.[3,4,5]

It is interesting to note that less than 20 per cent of genitourinary melanoma metastases are diagnosed prior to death.[2,4] This is most likely due to the "silent" nature of urinary tract involvement.

Antemorten diagnosis can be readily achieved utilizing excretory urography to establish upper tract involvement, and cystoscopy with biopsy to confirm lower tract metastases. Melanuria previously has been regarded as pathognomonic of genitourinary melanoma.[6] Although its presence is helpful in establishing a diagnosis, melanuria may at times be difficult to detect and may also be seen in other disease states.[5]

In summary, urinary tract involvement is a common finding in disseminated melanoma. This case illustrates the ease of confirming the diagnosis of such a metastasis. The use of intravenous urography and cystoscopy should be employed in those patients who are being evaluated for possible recurrence of malignant melanoma.

### References


1. Corriero JN: Secondary melanoma of urinary bladder. *WV Med J* 51:298, 1955.

2. Goldstein HM, Kaminsky S, Wallace S, Johnson DE: Urographic manifestations of metastatic melanoma. *Am J Roentgenol, Radium Ther Nucl Med* 121:801, 1974.

3. Abeshouse BS: Primary and secondary melanoma of the genitourinary tract. *South Med J* 51:994, 1958.

4. Das Gupta T, Grabstald H: Melanoma of the genitourinary tract. *J Urol* 93:607, 1965.

5. Weinstock BI, Willscher MK, Novicki DE: Importance of urinary tract investigation in metastatic malignant melanoma. *Urol* 10:547, 1977.

6. Way SC, Light SE: Generalized melanosis. Report of a case with necroscopy. *JAMA* 94:241, 1930.


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## Can Turn You Red

That tasty Hawaiian seafood delicacy, mahimahi, can turn you red.

The medical term is scombroid fish poisoning. Its most common symptom is a flushing of the face in which the sufferer has the appearance of acute sunburn.

Robert Kim, M. D., of the Straub Clinic, Honolulu, reports on several instances of individuals suffering from poisoning after eating mahimahi. In addition to flushed face, the patient also sometimes had upset stomach, headache, nausea and general discomfort.

The report is in a recent issue of an American Medical Association specialty journal, Archives of Dermatology.

The condition, said Doctor Kim, is due to a toxin with histamine-like properties, which is formed when the fish is improperly refrigerated.

# Medical Grand Rounds

**From the West Virginia University Hospital**

Edited By
*Irma H. Ullrich, M. D.*
*Associate Professor of Medicine*

## Testicular Carcinoma

Discussants:
JOHN A. BELIS, M. D.
*Assistant Professor, Department of Urology*
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*Recent diagnostic and therapeutic developments have improved the survival of patients with testicular tumors. These improvements include the development of sensitive tumor markers for non-seminomatous tumors, the use of computerized tomography and lung tomography in diagnosis, and improved chemotherapeutic agents for the treatment of disseminated tumors.*

*Despite these important advances in the management of testicular tumors, certain problems remain in the initial approach to these patients. These problems include delay in diagnosis, epididymitis which may mask a tumor, or difficulties with the initial surgical approach to the tumor.*

TESTICULAR tumors constitute the most common solid tumor in males between the ages of 15 and 35 and occur in 2.2 per 100,000 males per year in the United States.[1] Approximately 2,500 new cases are diagnosed annually.[2] Despite the high incidence of this malignant tumor in young men, tumors of the testis comprise only two per cent of all male cancers.

The incidence of testicular tumors in patients with a known history of cryptorchidism is considerably higher than in normal men.[3] Up to 6.5 per cent of tumors occur in cryptorchid testes.[2] This incidence does not appear to be altered significantly by orchiopexy.[3] However, the degree of cryptorchidism is related to the incidence of malignant degeneration. While the incidence of malignancy of an inguinal testis is approximately five times that of a normally-positioned testis, the incidence of malignancy in an intra-abdominal testis is nearly 35 times greater than in a normal testis. Therefore, frequent examination of a cryptorchid testis after orchiopexy is mandatory. This can best be achieved by self-examination along with a yearly examination by a physician.

Approximately 35 per cent of patients have lymphatic dissemination or distant metastases at the time of diagnosis.[2] In patients who do not respond to therapy, death usually occurs from complications of pulmonary metastases.

### Signs and Symptoms

The majority of testicular tumors are asymptomatic, and present as painless enlargement. However, pain or epididymitis is present in up to 25 per cent of patients and frequently can lead to an incorrect diagnosis. A patient with epididymitis should have repeated examination of the scrotal contents during therapy to be certain that the testis which initially may not have been palpable can later be examined and found to be normal.

The duration of a testicular mass is also important in the ultimate prognosis. Patients who have a known mass or symptoms for less than three months have a much lower incidence of metastases at the time of diagnosis and have a much better prognosis than patients who have had a mass, or symptoms associated with a mass, known to them for more than three months.[4]

### Histopathology

Testicular tumors may be categorized into germ-cell tumors, which account for approximately 94 per cent of all testicular tumors, and gonadal stromal tumors, which comprise the remaining 6 per cent.[1] The present discussion will focus upon germ-cell tumors. These may be subdivided according to histopathology as shown in Table 1.

Pure seminoma comprises approximately 40 per cent of germ-cell tumors.[5] These tumors are extremely radiosensitive and are curable in more than 90 per cent of patients. The remaining germ-cell tumors may be classified as non-seminomatous, and respond best to a combination of surgery and chemotherapy. This group includes embryonal carcinoma, teratoma, choriocarcinoma, and various combinations of these cell types. The entire group of tumors can be further subdivided histologically according to cell morphology, and this can be of additional value in diagnosis and therapy.[1]

Secondary testicular tumors should also be discussed at this point. Malignant lymphoma is the most common secondary tumor of the testis that initially presents as a primary tumor.[3] Most of these tumors occur in older men, and the majority of these patients eventually die of generalized lymphoma. Other secondary testicular tumors are uncommon and most often originate from prostate, lung, skin (malignant melanoma), kidney and colon.

### Staging

A number of methods exist for the staging of testicular cancer. The purpose of staging in this malignancy is to provide an accurate assessment of local spread, metastases to retroperitoneal lymphatics and their extent, and metastases beyond the retroperitoneum and their extent. The staging of these tumors is briefly presented in Table 2. Stage I refers to a tumor which is confined to the testis. A Stage II tumor has metastasized to the retroperitoneal lymph nodes, while a Stage III tumor has metastasized beyond retroperitoneal lymph nodes.

**TABLE 1**
**Histopathology of Testis Tumors in Adults**

1. Germ-cell tumors
   - A. Seminoma
   - B. Embryonal Carcinoma
   - C. Teratoma
   - D. Choriocarcinoma
   - E. Mixed-cell types
2. Gonadal stromal tumors
3. Secondary tumors

**TABLE 2**
**Staging of Testis Tumors**

| | |
|---|---|
| Stage I | —Tumor confined to one testis without evidence of metastases |
| Stage II | —Clinical or radiologic evidence of metastases to retroperitoneal lymph nodes |
| Stage III | —Metastases beyond retroperitoneal lymph nodes |

The diagnostic methods used in the staging of testicular tumors include serum tumor markers, computerized tomography of the retroperitoneum, and lung tomography.[2] Inferior vena cavography and pedal lymphangiography can be useful in the assessment of bulky retroperitoneal metastases, but they are no longer advocated in routine evaluation. The role of each of these diagnostic studies in the evaluation and staging of testicular cancer will be discussed.

### Tumor Markers

First, let's look at the serum tumor markers. These markers include alpha-fetoprotein (AFP) and $\beta$-human chorionic gonadotropin ($\beta$-HCG).[6] Both serum markers are quantified by extremely sensitive radioimmunoassays. The radioimmunoassay of $\beta$-HCG should not be confused with the previously used bioassay for urinary HCG. The bioassay is much less sensitive and no longer recommended as a diagnostic test. AFP is an $\alpha$-1-globulin which is produced in the liver, yolk sac, and gastrointestinal tract of the fetus. Significant amounts of AFP remain in circulation during infancy, but normal adult levels are less than 20 nanograms per ml. Serum AFP is elevated in some patients with cancers of the testes, liver, pancreas, stomach, colon and lung. This tumor marker is elevated in 75 per cent of non-seminomas, and is not elevated in seminomas. When this tumor marker is elevated it is an extremely accurate reflection of the continued presence or recurrence of a testicular tumor. AFP in the peripheral circulation has a half-life of five days. It is important to remember this when assessing AFP levels before and after treatment. One should wait for a period of five half-lives or 25 days to assess accurately a change in AFP level induced by therapy.

$\beta$-HCG is a glycoprotein secreted by the placenta and normally found in serum only during pregnancy. Normal serum levels of $\beta$-HCG in the adult are less than one nanogram per ml. The $\beta$ subunit of HCG is important as a tumor marker because it is unique to HCG, while the $\alpha$-subunit of HCG is similar to the $\alpha$-subunit of LH, FSH, and TSH. $\beta$-HCG is elevated in some

cancers of the testis, breast, liver and stomach. This tumor marker is elevated in approximately 60 per cent of non-seminomas and is elevated in approximately 5 per cent of seminomas.[7] However, the occasional elevation of $\beta$-HCG in a patient who appears to have a histologically-pure seminoma reflects elements of choriocarcinoma mixed with the seminoma. The amount of choriocarcinoma in the testis of these patients may be small but the quantity of this component is often greater in the metastases. An immunoperoxidase stain is necessary to detect the small amounts of choriocarcinoma present in histological sections of the testis.[7] This information is important in the therapy of a patient with seminoma. A tumor composed of seminoma plus choriocarcinoma requires more extensive combined therapy than does a pure seminoma which responds readily to radiation therapy.

In addition, new investigational work is currently being performed to assess the value of a radioimmunoassay for urinary HCG levels in patients who are apparently in remission from testicular cancer.[2] Preliminary information on this test suggests that radioimmunoassay of urinary HCG on a 24-hour specimen may reflect the presence of residual or recurrent tumor more accurately than the current radioimmunoassay for serum $\beta$-HCG.[2]

The second diagnostic modality which is useful in the assessment of metastases from testicular tumors is computerized tomography (CT).[8] While the value of CT compared to pedal lymphangiography in the diagnosis of early metastases to retroperitoneal lymph nodes has not been established, both of these diagnostic methods are obviously limited in the detection of microscopic metastases. However, CT is valuable in the assessment of retroperitoneal metastases when enlargement of lymph nodes is present. This information can be helpful in preoperative staging of tumors and in the follow-up of patients after retroperitoneal lymphadenectomy and/or chemotherapy. By use of CT the hazards of pedal lymphangiography can be avoided in the majority of patients.

Finally, lung tomography is useful in staging. Lung tomograms can often detect small metastatic deposits which are not obvious on plain chest film. This information certainly can alter the approach to therapy.

### Management

The treatment of germ-cell testicular tumors should be approached in a multidisciplinary fashion allowing the surgeon, radiation therapist and chemotherapist to treat the individual patient according to the stage and histological type of tumor present.[9] Such regimens should be initiated and maintained at centers where all necessary diagnostic and therapeutic modalities are available. Surgery must be aggressive, often extensive, and as complete as possible, while radiation therapy and chemotherapy involve considerable toxicity and require careful monitoring.

Some aspects of the therapy of testicular tumors have not been clearly established, or remain controversial. However, certain general statements can be made. In all cases the primary tumor in the testis should be removed through an inguinal incision with high ligation of the spermatic cord. Scrotal incisions should be avoided because of the possible contamination of scrotal lymphatics with tumor, and subsequent metastasis to inguinal lymph nodes which complicate further therapy and alter the prognosis. Needle aspiration of testicular masses through the scrotal skin should not be done for similar reasons.

Pure seminomas with negative tumor markers respond extremely well to radiation therapy. Non-seminomatous germ-cell tumors of the testis and tumors which consist of a mixture of seminoma and other cell types respond best to a combination of retroperitoneal lymphadenectomy and chemotherapy. The current role of radiation therapy in non-seminomatous testicular tumors that do not respond well to the combination of surgery and chemotherapy has not been established. The surgical approach to retroperitoneal lymphadenectomy and its use in conjunction with chemotherapy has been addressed by several authors and will not be elaborated upon in this discussion.[2,10-12]

### Chemotherapy

*Seminoma*: Most seminomas are cured by surgery and radiation therapy even when there is obvious para-aortic node involvement.[13] Ex-

**TABLE 3**

**Single-Agent Chemotherapy In Seminoma**

| *Drug* | *Overall Response Rate* |
|---|---|
| Melphalan | 90% |
| Chlorambucil | 100% |
| Cyclophosphamide | 100% |
| Actinomycin-D | 66% |
| Mithramycin | 31% |
| Adriamycin | 50% |

perience with chemotherapy is rather limited. Many drugs have shown activity against this tumor (Table 3), and this forms the basis for using single alkylating agents as the standard therapy for metastatic seminomas. Combination chemotherapy has not been studied extensively in this disease, but initial studies with a combination employing cis-diamminedichloroplatinum have demonstrated encouraging results. Einhorn obtained responses in 12 of 13 patients with Stage III seminomas including nine complete responses.[14]

*Non-Seminomatous Tumors*: Many patients with non-seminomatous tumors relapse after initial therapy or present with metastatic disease and, therefore, experience with chemotherapy is more extensive with these histological types. Chemotherapy prolongs survival only when a complete response is obtained. Ninety-five per cent of relapses occur within 36 months of the end of therapy. Favorable factors in achieving complete remissions include: age less than 30, metastatic disease limited to lungs and lymphatics, and no prior chemotherapy. Of the various non-seminomatous tumors only choriocarcinoma appears to be significantly less responsive than the other types.[15]

Although many chemotherapeutic agents have activity against non-seminomatous tumors (Table 4), many of these responses are not complete and of short duration. This led to the use of combination chemotherapy. Initial studies included actinomycin-D and alkylating agents. These combinations resulted in more complete responses, but overall survival was not increased. Samuels *et al.* introduced regimens employing bleomycin and vinblastine.[16] Since then many trials have shown these combinations to be effective in producing complete responses (Table 5).

**TABLE 4**

**Single-Agent Chemotherapy In Nonseminomatous Testicular Germ-Cell Tumors**

| *Drug* | *Overall Response Rate* |
|---|---|
| Melphalan | 25% |
| Cyclophosphamide | 89% |
| Methotrexate | 40% |
| Vinblastine | 48% |
| Actinomycin-D | 26% |
| Mithramycin | 33% |
| Bleomycin | 35% |
| Adriamycin | 29% |
| Cis-Diammine Dichloroplatinum | 61% |

Cis-diamminedichloroplatinum (DDP) was introduced in clinical trials in 1972 and found effective as a single agent against non-seminomatous testicular tumors. Later, DDP was used in combination with vinblastine and bleomycin in many trials (Table 6). VAB II and VAB III were parts of a series of protocols using a combination of vinblastine, actinomycin-D, bleomycin and DDP. The VAB II study which included these drugs had an overall response rate of 84 per cent with 50 per cent complete remissions and 22 per cent long-term survivors. This was a marked improvement over the VAB I protocol using vinblastine, bleomycin and actinomycin-D in which there were only 14 per cent long-term survivors. The VAB III protocol included cytoxan and adriamycin in addition to the four drugs in VAB II. Overall and complete responses with VAB III were similar to VAB II, but there were 49 per cent long-term survivors.

**TABLE 5**

**Combinations Using Vinblastine And Bleomycin**

| *Drugs* | *Complete Remission Rate* |
|---|---|
| VLB, BLEO, CYT, MIT, ACT | 36% |
| VLB, BLEO | 44% |
| VLB, BLEO | 33% |
| VLB, BLEO, ADR | 12% |
| VLB, BLEO, ACT | 45% |

VLB = Vinblastine; ADR = Adriamycin
BLEO = Bleomycin; CYT = Cytoxan
MIT = Mithramycin; ACT = Actinomycin-D

**TABLE 6**

**Combinations Using Vinblastine, Bleomycin And *cis* DDP**

| | *Overall Response Rate* | *Complete Remission Rate* |
|---|---|---|
| VAB II<br>VLB+ACT+BLEO+DDP | 84% | 50% |
| VAB III<br>VLB+ACT+BLEO+DDP+CYT<br>Followed By<br>VLB+CLB+ADR+ACT | 86% | 60% |
| Einhorn<br>DDP+BLEO+VLB<br>Followed By<br>VLB | 100% | 70% |

VLB = Vinblastine; CYT = Cytoxan
ACT = Actinomycin-D; CLB = Chlorambucil
BLEO = Bleomycin; ADR = Adriamycin
DDP = Diamminedichloroplatinum

Einhorn treated 47 patients with vinblastine, bleomycin and DDP to produce an overall response rate of 100 per cent.[14] Thirty-three patients achieved complete remission and 29 were long-term survivors. Patients with advanced abdominal and pulmonary metastases did poorly, but there were 19 complete responses among 22 patients with minimal metastases.

Advances in chemotherapy have contributed significantly to improved survival in patients with testicular cancer. However, most of the chemotherapeutic regimens employed result in considerable toxicity.[17] At the present time efforts are focused upon alterations of chemotherapeutic regimens to reduce overall toxicity without sacrifice of efficacy. As new combinations of chemotherapy are developed it appears that metastatic testicular cancer is potentially a curable disease.

### Delay in Diagnosis

Despite the recent advances in the management of testicular tumors, delay in diagnosis continues to affect adversely the survival of these patients. All too frequently, a patient seeks medical attention concerning a painless scrotal mass which has been known to the patient for a number of months. Multiple reasons exist for this delay. The individual may ignore asymptomatic testicular enlargement, reasoning that what is not painful is not serious. He may also believe that a larger testis makes him more virile. Of course, the fear and subsequent denial that a cancer may be present is often the major reason for procrastination in seeking medical advice. Only improved public education regarding cancer can overcome this difficulty. Certainly the physician should avoid contributing to a delay in treatment of a testicular tumor. Physical examination, particularly in young men, should include a careful bimanual palpation of each testis. Epididymitis which fails to respond promptly to therapy should also be regarded with suspicion. Finally, inability to palpate the testis of a young man because of a hydrocele should lead to further investigation.

Another problem which occurs in the initial management of testicular tumors prior to referral to a urologist is contamination of the scrotum by tumor cells either through direct exploration through a scrotal incision or by needle aspiration of the tumor through the scrotal wall.[18] Violation of the scrotum should be strictly avoided in all testicular masses because alteration in lymphatic drainage will occur and allow metastases to the inguinal region and abdominal wall. All cases known to have a contaminated scrotum, including those cases which have had a previous orchiopexy for cryptorchidism, should be treated with hemiscrotectomy and ipsilateral inguinal lymphadenectomy. In patients who have had a prior orchiopexy for cryptorchidism it is important that the patient be instructed in self-examination of his testis so that a tumor may be detected early. This self-examination should be confirmed by a yearly examination by a physician.

### Diagnosis Delay Diminishes Prognosis

A review of patients who have presented at West Virginia University with testicular tumors over the past 10 years has confirmed that both a delay in diagnosis for more than three months or a problem in the initial management of the tumor contribute to a diminished prognosis.[4] The overall survival in patients who presented with a tumor of less than three months' duration was 81 per cent, while the overall three-year survival of patients who had a known tumor in the testis for greater than three months was only 60 per cent. The number of patients who had a known testicular tumor for more than three months presented with Stage III disease at a rate 10 times greater than those patients whose testicular mass was known to be present for less than three months.

The patients in our series who presented with prior scrotal contamination also did not do well despite intensive therapy; five of eight patients in this category died from their tumor.

Another difficulty occasionally encountered in the initial management of a testicular tumor is a patient who presents with an abdominal mass and no obvious source of a primary tumor, including an examination of the testis which is normal. After exploration of the abdominal mass the histological report returns as a testicular tumor. Repeated examination of each testis again fails to reveal an obvious mass. It is possible to develop an extratesticular primary germ-cell tumor. However, in many cases a very small primary, usually less than one cm in diameter, is present in the testis. These lesions can be soft and non-palpable. Recent advances with ultrasonography of the testis appear promising in the early diagnosis of such lesions when an extratesticular germ-cell tumor is discovered and the source of the primary is not obvious.

In conclusion, significant advances continue to be made in the treatment of testicular tumors. An aggressive, multidisciplinary approach is necessary for optimal management. Delay in diagnosis remains a serious problem. Careful attention must be devoted to the scrotal exami-

nation by all physicians. Every testicular mass should be considered a potential tumor and approached aggressively. In addition to future diagnostic and therapeutic advances, improved survival may be obtained through early diagnosis and proper initial management.

### References


1. Mostofi FK: Testicular tumors. *Cancer* 32:1186-1201, 1973.

2. Javadpour N: The National Cancer Institute experience with testicular cancer. *J Urol* 120:651, 1978.

3. Martin DC: Germinal cell tumors of the testis after orchiopexy. *J Urol* 121:422, 1979.

4. Belis JA, Kandzari SJ, Milam DF: Management of testis tumors. *WV Med J* 74:259, 1978.

5. Nochomovitz LE, DeLa Torre FE, Rosai J: Pathology of germ cell tumors of the testis. *Urol Clin* NA 4:359, 1977.

6. Lange PH, Fraley EE: Serum alpha-fetoprotein and human chorionic gonadotropin in the treatment of patients with testicular tumors. *Urol Clin NA* 4:393, 1977.

7. Javadpour N, McIntire KR, Waldmann TA, Bergman SM: The role of alpha-fetoprotein and human chorionic gonadotropin in seminoma. *J Urol* 120:687, 1978.

8. Javadpour N, Anderson T, Doppman JL: Computed tomography in evolution of testicular cancer during intensive chemotherapy. *J Urol* 122:565, 1979.

9. Donohue JP, Einhorn LH, Perez JM: Improved management of nonseminomatous testis tumors. *Cancer* 42:2903, 1978.

10. Donohue JP: Retroperitoneal lymphadenectomy: The anterior approach including bilateral suprarenal-hilar dissection. *Urol Clin NA* 4:509, 1977.

11. Skinner DG: Surgical management of advanced non-seminomatous tumors of the testis. *Urol Clin NA* 4:465, 1977.

12. Donohue JP, Perez JM, Einhorn LH: Improved management of non-seminomatous testis tumors. *J Urol* 121:425, 1979.

13. Maier JG, Mittlemeyer BT, Sulak MH: Treatment and prognosis in seminoma of testis. *J Urol* 99:889, 1966.

14. Einhorn LH, Donohue JP: Cisdiamminedichloroplatinum, vinblastine and bleomycin combination chemotherapy in disseminated testicular cancer. *Ann Intern Med* 87:293, 1977.

15. Katz ME, Grossback AB, Wein A: Testicular germ cell tumors: Diagnosis, management and the potential for cure. *Cancer Clin Trials* 1:247, 1978.

16. Samuels ML, Lanzotti VJ, Holoye PY, Boyle LE, Smith TL, Johnson DE: Combination chemotherapy in germinal cell tumors. *Cancer Treat Rev* 3:185, 1976.

17. Krikorian JG, Daniels JR, Brown BN, Hu MSJ: Variables for predicting serious toxicity (vinblastine dose, performance status, and prior therapeutic experiences): Chemotherapy for metastatic testicular cancer with cis-dichlorodiammineplatinum (II), vinblastine, and bleomycin. *Cancer Treat Rev* 62:1455, 1978.

18. Markland C, Kedia K, Fraley EE: Inadequate orchiectomy for patients with testicular tumors. JAMA 224:1025-1026, 1974.


# Detecting Reading Disability

Early detection of dyslexia, a reading disability, by means of a computer-assisted technique is reported in a recent issue of the American Medical Association publication, "Computers and Medicine."

"If children can be identified before they experience reading failure, and given appropriate aids to improve their reading function, they will be better armed to cope with the disability," said Frank H. Duffy, M. D., of the Childrens Hospital Medical Center in Boston.

Using a new computer-based technology called BEAM (Brain Electrical Activity Mapping), researchers have been able to distinguish between disorders caused by anatomical abnormalties (such as tumors) and functional disorders (such as dyslexia). Doctor Duffy points out that objective and noninvasive methods for diagnosing dyslexia, such as BEAM, will prove vital to detection at preschool age.

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*A message from . . .*

*The President*

## A YEAR OF OPPORTUNITY

CRUCIAL is an overworked adjective. What better word, however, might I choose to describe 1980 in terms of its political consequences for Medicine?

We have been fortunate. Inflation and depression have deflated any windy talk about National Health Insurance. Malpractice litigation concerns are temporarily on a back burner because of the availability of liability insurance. Others have shared with us the bureaucratic malevolence of the FTC and have joined with us in fending off that nuisance via the courts. The courts themselves, however, threaten to breech the curtain of confidentiality that enables us to deal in candor with our patients and with each other.

None of these problems will disappear in 1980, no matter the strength of our wishes. Each requires thought, planning, work and the good fortune that results from hard work. Each calls for corrective legislation at state and national levels.

To get this legislation requires, if not friendly legislators, at least open-minded legislators. In this year we have an opportunity to open minds or to retire into well deserved obscurity some notoriously closed minds.

These legislative goals will perhaps not be met in 1980. But they can be approached. We can very definitely create a much more receptive mood for the consideration of our concerns, our ideas and our proposals in both Charleston and Washington.

We can do this with your help. To this end I commend to you membership and active involvement in the West Virginia Medical Political Action Committee (WESPAC). Those of you not presently members will very shortly receive a letter soliciting your active support of WESPAC activities.

I take this opportunity to reinforce that plea. Your response will greatly enhance the prospects for all of us to have a happy and satisfying year during 1980.

My personal wishes go out to every member of the West Virginia State Medical Association to have, indeed, a professionally and personally satisfying and Happy New Year.

Stephen D. Ward, M.D.

STEPHEN D. WARD, M. D., *President*

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

## VE AND YOU

The U. S. House of Representatives rejected, in late November, President Carter's hospital cost controls bill. The vote against the bill, and for a substitute without mandatory controls, was a stunning 234 to 166. It was a bitter defeat for the President, who had insisted that passage of his measure was necessary before consideration could be given to national health insurance.

At the same time, the vote was a major victory for health care providers—but it was a victory underlined by major new challenges to continue unabated the Voluntary Effort into which major efforts have been channeled by the American Hospital Association, American Medical Association, Federation of American Hospitals, local and state hospital and medical societies and numerous other organizations.

"We renew our pledge to the American people and President Carter to fight inflation with every resource at our command. We applaud Congress for its support of the demonstrated ability of the private sector to control hospital costs voluntarily," said Dr. James H. Sammons, Executive Vice President of the AMA.

The story of the Voluntary Effort has been told over and over again for the past two years or so. It has succeeded in reducing hospital expenditures while inflation has continued to mount in the general economy. National figures have shown that the rate of increase in hospital expenses went down nearly three percentage points (from 15.6 per cent to 12.8 per cent) from 1977 to 1978.

In West Virginia, according to the best figures the West Virginia Hospital Association has been able to assemble, the rate of increase dropped from 16.36 per cent (higher than the national figure) in 1977 to 12.47 per cent (below the national percentage) in 1978.

There have been solid, increased efforts by West Virginia hospital boards, administrators and medical staffs to make the Voluntary Effort productive. The record indicates that real, heartening progress has been made. But more—much more—still needs to be done.

The national goal called for a further two-per cent reduction, to 11.6 per cent, in the rate of hospital cost increases in 1979. With the overall inflation rate running well above that figure, the goal offered a real challenge.

The West Virginia Hospital Association recognized that 1979 represented a "crucial year for VE." But so do 1980, and probably other years ahead. Doctor Sammons said he could assure Congress that its confidence in the private sector has not been misplaced.

West Virginia physicians must join with counterparts everywhere to give all possible substance to Doctor Sammons' assurance. The task is most difficult, but one that can be accomplished.

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## PARADOX

After several years of development, complicated by contract and legal difficulties, the West Virginia Department of Welfare is implementing its highly computerized Medicaid Management Information System (MMIS) for the processing of Medicaid claims and compilation of other data.

The Department has said that the new system will bring substantial administrative savings, probably running into millions of dollars a year. But is that the whole story?

It would appear that it will take the welfare agency considerable time just to balance off large amounts of federal and state funds extended to get the system in place before it can take comfort in administrative savings. Among other problems encountered, its first contractor ran into financial difficulties and the agency largely had to start over from ground zero.

Then there is the problem, particularly for the state's hospitals, of provider changeover to new forms and a new data base. We don't have any

specific figures as to this cost, but hospitals have indicated, collectively, it can run several hundreds of thousands of dollars statewide.

Presumably, there will be some front-end administrative costs, at least, for physicians and other health care providers, too, in adapting to the new invoice format and getting office personnel prepared to handle it.

All of this means, it appears, one thing—again. Such costs will be in some manner be passed along to patients and the general public. So once more we face the inevitable paradox relative to operation of government programs. There might be some administrative savings at the agency level, but at least in the early operation of the new program, additional costs will be a problem elsewhere.

Remaining to be determined is whether, over the long run, the system can, and will, prove itself.

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**TROUBLE WITH FOIA**

On its face, a federal statute such as the Freedom of Information Act (FOIA) doesn't appear to be a major problem. It was one outgrowth of the politically volatile 1960s, the American involvement in Vietnam and the Watergate coverup.

When originally enacted by the Congress in 1966, it was designed to promote full disclosure to the public of administrative operations, procedures and records of federal agencies.

But as with most statutes, interpretations of the act now have been evolving for some time. Unforseen consequences have provoked amendments that emphasize the public's right or provide exemptions to the disclosure requirements. However, these amendments have been of little help for many problems that health science personnel, in particular, face under the law.

In fact, while few of them might like to admit it, even politically liberal scientists are becoming anxious and angry about ways that disclosure requirements of FOIA can be manipulated to obtain data on government-supported research.

Even those liberals are beginning to cite troublesome experiences, and to clamor that some "safeguard" amendments are needed to protect against costly abuses of the act. Apparently, such abuses are becoming increasingly easy to find.

One story tells how a journalist demanded early "rat-by-rat" results of a long-term bit of study and scientific research. As a government rather than a corporate employee, the scientist working on the experiments had no patentable trade secrets concerning the research he needed desperately to protect. Consequently, he had no choice but to honor the journalist's request and hope that person would understand his warning about the unreliability and prematurity of interpretive data obtained early in a study.

This, in other words, is the type of demand that can be made under the FOIA which might involve incomplete or not-yet-validated clinical trials or observational epidemiologic studies—with the very real possibility that misunderstandings and serious misinterpretations of research might result.

What are the answers to this kind of a problem? There perhaps are no clear-cut solutions. But there is somewhat heartening evidence of a realization that a problem exists. Health scientists have been asked by federal officials in recent weeks to offer some feedback on just how difficult FOIA requirements are for them.

Now, we'll need to await the results, hopefully in the Congress.

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**ETHICAL CHALLENGE**

Medical ethics, like medicine itself, steadily gains new dimensions and presents us with new challenges. Today, no challenge is greater or timelier than the deceleration of health-care costs. And it's truly an ethical challenge.

Considerations for the bills that patients pay is integral to respecting patients as human beings. And that respect is where ethics begins.

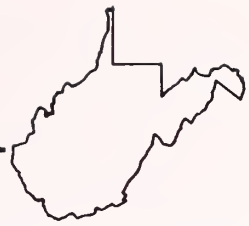
Valuable guidance in carrying out the cost ethic is provided by the report of the National Commission on the Cost of Medical Care that the American Medical Association sponsored.

All of us, and each of us, must take it upon ourselves to activate the Commission recommendations that have been approved by the AMA House of Delegates. We must make them an organic part of the daily consciousness and conduct of our profession.

It must be stressed, however, that if we are to exert a maximum good influence on ethics and other growing issues, our Association must make maximum use of its physician representation from all segments of our profession.

Every physician in this land has a membership in the problems that the Association copes with in his or her behalf. So let's have fuller membership in the Association and its solutions.

# GENERAL NEWS



## Hepatitis, Smoking, Ultrasound Speakers Announced

Papers by three physicians, on viral hepatitis, smoking and ultrasound will complete the program for the 13th Mid-Winter Clinical Conference to be held January 25-27 in Charleston at the Holiday Inn Charleston House.

The Program Committee announced the three speakers will be: Stephen M. Feinstone, M. D., Medical Officer, Hepatitis Virus Section, Laboratory of Infectious Diseases, National Institute of Allergy and Infectious Diseases, Bethesda, Maryland; Daniel Horn, Ph.D., Frenchtown, New Jersey, former Director, National Clearinghouse for Smoking and Health, U. S. Public Health Service; and Michael T. Hogan, M. D., Morgantown, radiologist and Associate Professor of Radiology, West Virginia University Hospital.

The annual continuing medical education event, sponsored by the State Medical Association and West Virginia and Marshall University Schools of Medicine, will begin at 2 P. M. on Friday, January 25, and conclude at noon on Sunday. (Printed programs were mailed to all Association members in early December.)

Doctor Feinstone will speak on "Update on Viral Hepatitis" during the Friday afternoon session; Doctor Horn, "What Can We Do About Young People Smoking?," Friday evening public session, and "What Should the Physician Be Doing About Smoking?," Saturday morning physicians' session; and Doctor Hogan, "Diagnostic Ultrasound of the Abdomen," Sunday morning.

Doctor Feinstone has been in his present post with the National Institute of Allergy and Infectious Diseases (NIAID) since 1976, and also was a research associate in NIAID's Laboratory of Infectious Diseases from 1971 to 1974.

His research interests are virology and clinical infectious diseases.

A native of Greenwich, Connecticut. Doctor Feinstone was graduated from Johns Hopkins University and received his M. D. degree in 1969 from the University of Tenessee College of Medicine.

He completed a fellowship in infectious diseases and his internship at the Medical College of Wisconsin, and his residency at Georgetown University Hospital.

Doctor Feinstone is a member of the American Federation of Clinical Research and the American Society for Microbiology. He is the author or co-author of some 28 scientific articles.

#### 1979 Award Recipient

Doctor Horn was the recipient of the 1979 Edward W. Browning Award for outstanding achievement in the prevention of disease; he has been a major force behind the movement that has led the public to understand that smoking is a major cause of disease and disability. The award was established in honor of the late Edward W. Browning, a real estate entrepreneur, and is administered by the New York Community Trust in New York City.

A psychologist, Doctor Horn gained an interest in the effects of smoking during the decade, beginning in 1947, when he served as Assistant Director of Statistical Research at the American

## Insurance Official Approves 1980 Aetna Filing

November 30 action by State Insurance Commissioner Richard Shaw brought approval of premiums filed by Aetna Life & Casualty for 1980 for the State Medical Association-sponsored professional liability insurance program. Details of the filing were provided Association members in a September 14 memorandum from the State Office.

Meanwhile, the Association's Ad Hoc Committee on Professional Liability, chaired by Dr. Jack Leckie of Huntington, will begin study at a January 12 meeting in Charleston of possible alternatives in the way of malpractice insurance coverage for West Virginia physicians.

Such a study was directed by Council, and supported by the Committee on Insurance, at a special September 9 meeting at which Aetna representatives, in an annual report to the Association leadership, outlined current program experience and explained the 1980 premium filing catalog for a 16.9-per cent increase in basic coverage.

Cancer Society. At that time, statistical findings were emerging which linked cigarette smoking and rising death rates.

In 1952, Doctor Horn published, with Dr. E. Cuyler Hammond, a landmark paper on "Tobacco and Lung Cancer" based on a study of United States veterans. In 1954, Horn and Hammond again collaborated on a paper, "The Relationship Between Smoking Habits and Death Rates," which, through the public attention it received, brought about a greater awareness of the hazard of smoking.

After 15 years with the American Cancer Society, Doctor Horn joined the U. S. Public Health Service as Assistant Chief for Research, Cancer Control Program. Division of Chronic Diseases. It was in that capacity that he was a part of the development which history may see as the watershed in the understanding of smoking: "The Surgeon General's Report on Smoking and Health," which was released in January of 1964. The publicity that surrounded that report led to the decline in adult male smokers, which has continued, with some reversals, until today.

The next year, Doctor Horn was appointed Director of the new National Clearinghouse for Smoking and Health within the Public Health Service. During his 12 years in that position, he supervised numerous studies on the smoking habits of adults, of youth and of health professionals, and pioneered in education programs designed to help individuals make informed choices about smoking and other behaviors that affect health.

**Albany, New York, Native**

A native of Albany, New York, Doctor Hogan is certified by the American Board of Radiology and the American Board of Nuclear Medicine.

He presented papers on "Urinary Tract Ultrasound" at a meeting of the Mid-Atlantic Section of the American Urological Association in February, 1977, in Charlottesville, Virginia, and "Full Lung Tomography" at the meeting of the Virginia-West Virginia State Radiological Association in April, 1976, in Hot Springs, Virginia.

Doctor Hogan was a visiting professor in diagnostic ultrasound at Weirton General Hospital in December, 1976, and in abdominal ultrasound at Mary Imogene Bassett Hospital in April, 1977, in Cooperstown, New York.

He is the author or co-author of a number of scientific articles, including two in *The West Virginia Medical Journal.*

Doctor Hogan was graduated from Holy Cross College and received his M. D. degree in 1967 from Albany (New York) Medical College. He interned at Grady Memorial Hospital in Atlanta, and took his residency at North Carolina Memorial Hospital in Chapel Hill. He also did postgraduate work at Episcopal Hospital in Philadelphia in 1973.

Doctor Hogan is a member of the American Institute of Ultrasound in Medicine.

The opening session on Friday afternoon will begin with remarks by Stephen D. Ward of Wheeling, President of the West Virginia State Medical Association.

**Doctor Mou to Preside**

Presiding at the opening session, "Infectious Diseases Update," will be Thomas W. Mou, M. D., Dean, WVU Charleston Division, and Acting Vice Chancellor for Health Sciences Education, West Virginia Board of Regents.

In addition to Doctor Feinstone the speakers and their topics will be "Recent Advances and New Problems in Diagnosis and Treatment of Meningitis"—Robert H. Waldman, M. D., WVU Professor and Chairman of Medicine, and "Reye's Disease, a Primary Care Problem: Diagnosis and Treatment"—John C. Partin, M. D., Professor of Pediatrics, University of Cincinnati College of Medicine; Director, Division of Gastroenterology and Microbiology Laboratory, Cincinnati Children's Hospital, and Director, Clinical Research Center, Children's Hospital Research Foundation, Cincinnati.

Held concurrently with the 8 o'clock public session Friday evening will be a physicians' session, a "CPR Workshop," which will be conducted by Emergency Medical Services Operation, Region 34, Inc. (EMSOR), Inc.) of Charleston.

Presiding for the workshop will be William H. Carter, M. D., Cardiologist, Charleston Area Medical Center; WVU Clinical Professor of Medicine, and President, American Heart Association, West Virginia Affiliate.

**Doctor Page to Open Workshop**

Dr. Jack R. Page, Chief, Department of Emergency Medicine at Charleston Area Medical Center, will open the workshop with a talk on the importance of the CPR program and standardizing CPR techniques.

The remainder of the time will be provided for physicians to work on the "Recording Annie" to see how closely their CPR techniques meet those of the American Heart Association. Instructors and instructor-trainees from the Kanawha County CPR Club will help grade the recording strips and assist doctors.

EMSOR, Inc., also will have an exhibit on the Advanced Cardiac Life Support Course (in the same room with the workshop, the Dodson Room).

In addition to Doctor Horn, as noted, there will be two other speakers for the concurrent Friday evening public session on "Drug Abuse, Smoking and Alcoholism."

Jack M. Rogers, M. D., Associate Professor in Psychiatry, Bowman Gray School of Medicine of Wake Forest University, Winston-Salem, North Carolina, will speak on "Drugs and the Now Society," while Maxwell N. Weisman, M. D., of Baltimore, Medical Director, Alcoholism Control Administration, Department of Health and Mental Hygiene, State of Maryland, will discuss "Alcoholism and the Teenager."

Presiding for the public session will be Eleanor Sankowski, Ph. D., Associate Superintendent for Curriculum and Instruction, Kanawha County Schools, Charleston.

For the Saturday morning physicians' session on "Drug Abuse, Smoking and Alcoholism," Doctor Rogers will speak on "The Doctor-Drug Dilemma," and Doctor Weisman's topic will be "The Alcoholic Physician: The Problem, Recognition and Treatment" (with Doctor Horn's subject noted above). Dr. William N. Walker, Jr., of Clarksburg will preside.

#### Doctor Jones to Preside

"Current Controversies in Medicine" is the title for the Saturday afternoon session. Presiding will be John E. Jones, M. D., Professor of Medicine and Dean of the WVU School of Medicine.

The speakers and their topics will be "The Dietary Treatment of the Adult Onset Diabetic" —Margaret J. Albrink, M. D., WVU Professor of Medicine; "Control of the Blood Sugar—Is That All There Is?"—Bruce S. Chertow, M. D., MU Professor of Medicine and Chief, Section of Endocrinology and Metabolism;

"Conservative Surgery for Breast Cancer"—Kenneth S. Scher, M. D., MU Assistant Professor of Surgery, and "Results of Radical Operations for the Cure of Cancer of the Breast"—Alvin L. Watne, M. D., Morgantown, WVU Professor and Chairman of Surgery, and Charleston Foundation Professor of Cancer Research.

A cash bar and hors d'oeuvres will be offered beginning at 5:30 p.m. on Saturday in the Hutchinson Room, but, as announced previously, there will be no Saturday evening dinner program this year.

The conference will conclude with a session on "Non-Invasive Techniques" Sunday morning.

Presenting papers in addition to Doctor Hogan, as noted, will be Ronald A. Savrin, M. D., Morgantown, WVU Assistant Professor of Surgery, and Director, Non-Invasive Peripheral Vascular Laboratory, on "The Non-Invasive Peripheral Vascular Laboratory;" and James T. Smith, M. D., Charleston radiologist; Director, Computed Tomography Laboratory, Charleston Area Medical Center, and WVU Clinical Assistant Professor of Radiology, "Computed Tomography."

Presiding will be George J. Hill II, M. D., MU Professor and Chairman of Surgery.

#### Exhibits, Related Activities

Exhibits and displays by voluntary health agencies and medical textbook publishers may be viewed during the entire conference in the Andrews Room.

Held in conjunction with the conference will be a dinner meeting of the Board of Directors of the West Virginia Chapter, American Academy of Family Physicians, at 6:30 P.M. on Thursday, January 24, at the Holiday Inn Charleston House, and a luncheon meeting of the West Virginia State Society of Anesthesiologists at noon on Saturday, January 26, in the Charleston House dining room.

Exhibits and other related meetings will be listed in a program insert at the time of the conference.

Also being held in conjunction with the conference is a Frostbite Frolic Run, a 10,000-meter run and a one-mile run for fun scheduled to begin at 8:30 A.M. on Saturday, January 26, at the WVU Medical Education Building, 3110 MacCorkle Avenue, S. E. Registration starts at 7 A. M.

Special awards will be given to physicians, house staff, medical students and nurses. The fee is $1 for Kanawha Valley Road Runners and $2 for non-members. Dr. Alfred K. Pfister of Charleston is arranging the run.

The conference program meets the criteria for 13 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association, and also is acceptable for 13 hours of Prescribed credit by the American Academy of Family Physicians.

#### Program Committee

Serving on the Program Committee are Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston, Co-Chairmen, and Drs. William O.

McMillan, Jr., Charleston; Maurice A. Mufson, Huntington; Robert L. Smith, Morgantown, and C. Carl Tully, South Charleston.

The committee is receiving assistance from WVU Charleston Division staff members J. Zeb. Wright, Ph.D., Coordinator of Continuing Education, Department of Community Medicine; and Sharon A. Hall, Conference Coordinator.

The conference registration fee will be $25 for physicians, with no fee charged for nurses, medical students, interns and residents. Advance registration is requested, with checks made payable to the West Virginia State Medical Association.

For overnight accommodations, physicians should communicate directly with the reservation manager of the hotel or motor inn of their choice. The conference headquarters hotel is setting aside rooms for registrants.

## MMIS, Uniform Claim Forms Now Scheduled in State

A recent State Supreme Court of Appeals decision has cleared the way for belated installation by the West Virginia Department of Welfare of its Medicaid Management Information System (MMIS).

A story in the May, 1979, issue of *The West Virginia Medical Journal* reviewed in detail features of the system, which originally was to go into effect for hospitals and pharmacies last July, and for physicians and other providers in August.

Another *Journal* story in the August, 1979, issue, told of litigation which developed over awarding by the State of a contract for the system to The Virginia Computer Company. A Kanawha Circuit Court order set aside the contract, but the lower court was reversed in Supreme Court review of the matter.

MMIS is a highly computerized system for processing medical and other invoices submitted to the welfare agency for payment, and for performing certain other data collection and related functions.

Information available from the Department as of about November 25 indicated the agency planned to bring hospitals into the new system in January; with physicians perhaps added in February.

The new system for billing for Medicaid services will require the use of new invoice forms. Also interrupted by the litigation were TVCC schedules for training seminars in various geographical locations in the State to permit physicians and appropriate office personnel to become familiar with the new forms. Physicians were to be kept informed by the Department of revised plans for such training and other reshaped system details.

### Uniform Claim Forms

Meanwhile, in another highly significant development, the Rockefeller Administration provided in late November its endorsement of the use of uniform health insurance and related claim forms in West Virginia.

A multi-faceted task force appointed by Insurance Commissioner Richard G. Shaw early in 1979 has been at work on this project. For physicians' services, a new plan to be subject to administrative and other hearings over the next few months will propose use of the American Medical Association-developed Uniform Health Insurance Claim Form already accepted by virtually all commercial insurance carriers and medical service (Blue Shield) plans.

Some additional time will be needed to bring governmental agencies into the uniform system, but such units as the Department of Welfare and the Workmen's Compensation Fund have provided additional assurances that they will move to comply as soon as practicable.

## Legislation, Building Plans Get Council Approval

The State Medical Association's Council endorsed at a November 18 meeting proposed legislation taking shape to re-write West Virginia's Medical Practice Act, and approved introduction of the bill in the 1980 legislative session to begin January 9.

Work on the legislation has followed the pattern set by a resolution adopted by the Association's House of Delegates during its annual meeting at the Greenbrier in August (for specifics of the resolution, please see page xxi of the October, 1979, issue of *The West Virginia Medical Journal*).

The Council also approved Committee on Legislation recommendations that bills in the form of a uniform brain death act; protection for utilization review committee, tissue committee and other similar minutes and records; and an alternative impaired physician provision be readied for legislative consideration.

The Council further voted to support, but not sponsor, child restraint legislation related to motor vehicle operation.

In other action, the Council:

—Approved further steps toward provision of a permanent headquarters building for the Medical Association (see related story in this issue of *The Journal*).

—Approved a general operating budget (exclusive of scholarship funds) of $376,224.01 for the Association for the 1980 calendar and fiscal year.

—Elected to retired membership in the Association, after appropriate component society action, Drs. C. Dudley Miller and William R. Turner, both of Huntington (Cabell Medical Society); and Charles H. Goodykoontz, Bishop, Virginia (McDowell Society).

—Bestowed honorary membership on Drs. Frederick H. Dobbs, John W. Hash and R. J. McNamara, all of Charleston (Kanawha Medical); and F. Floyd Blair of Walker, Russell L. Heinlein of Charleston and Walter R. Kohlheim of Tillamook, Oregon (all Parkersburg Academy of Medicine).

—Elected Dr. David Z. Morgan of Morgantown to the unexpired portion (to run through 1983) of the term of the late Dr. Edward J. Van Liere on the Publication Committee; and re-elected Dr. Vernon E. Duckwall of Elkins to a new seven-year term on the Committee, which also serves as the Editorial Board of *The West Virginia Medical Journal*, beginning January 1, 1980.

—Re-elected the following as nucleus members of the Board of the West Virginia Medical Political Action Committee (WESPAC): Drs. Stephen D. Ward of Wheeling, First Congressional District; N. B. Groves, Martinsburg, Second District; Joseph T. Skaggs, Charleston, Third District, and Frank J. Holroyd, Princeton, Fourth District.

—Elected as ex-officio members of the WESPAC Board Dr. Harry Shannon of Parkersburg, representing the Association Council; and Mr. Robert F. Bible, the Association's Staff Counsel, representing the Association's staff.

—Approved a request by Doctor Ward, the Association's President, for permission to establish a five-member Ad Hoc Committee on Long-Range Planning to establish goals, objectives and priorities for the Association, and to work as appropriate with continuing plans for an Association headquarters.

Doctor Ward also announced the appointment of Dr. Robert D. Hess of Bridgeport, the Council Chairman; Dr. Robert R. Weiler of Wheeling, and Dr. Louis C. Palmer of Bridgeport to a committee to conduct preliminary work related to other 1979 House action.

This resolution directed that officials and staff of the Association explore possibilities for holding the Annual Meeting at a site other than the Greenbrier; and report back to the House at its first session on August 20, 1980.

The Council took note of increased work and activity by several West Virginia physicians relative to Congressional consideration of hospital cost containment and other significant legislation; and directed that Executive Secretary Charles R. Lewis write letters of recognition and appreciation to those physicians.

## Further Planning Approved For Association 'Home'

Further steps designed to provide a permanent home for the State Medical Association within a few years were reviewed and endorsed by Council at its November 18 meeting in Charleston.

Dr. L. Walter Fix, the Association's President Elect and Chairman of an Ad Hoc Building Committee, and Executive Secretary Charles R. Lewis reviewed for Council the $78,000 purchase—finalized on November 1, 1979—of property measuring 75 feet by 150 feet in the Kanawha City section of Charleston.

Council then authorized Doctor Fix, upon his recommendation, to initiate steps to acquire additional property, 50 feet by 150 feet in size, immediately adjacent to that already purchased. It was estimated such a further acquisition would cost about $50,000.

Council accepted another recommendation by Doctor Fix that the Medical Association's total membership be assessed $30 each on January 1, 1980, to acquire the additional land. Council stipulated that the assessment, payment of which will be mandatory under Association By-Laws, be made on a one-time basis.

In further action, Council approved Doctor Fix's recommendation that he seek from contractors' representatives, at no cost to the Association, preliminary information as to the type, size, etc., of building which might be built on the property to meet future Association needs and other purposes which might later be determined.

It was understood that work of the Association's new Ad Hoc Committee on Long-Range Planning would be related closely to continued planning for a building.

## Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

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| Mar. 21 | Charleston | 7th Annual Newborn Day |
| Mar. 28-29 | Morgantown | Neurosciences Teaching Day |
| April 18 | Morgantown | 6th Annual ENT Teaching Day |
| April 19 | Wheeling | Annual Postgraduate Day in Surgery |
| April 26 | Morgantown | W. Va. Assn. of Pathologists, Scientific Session |

**Visiting Professors**

(Morgantown)

April 3-4 *Dept. of Obstetrics and Gynecology*: "Perinatal Outcome in Pregnant Epileptics" and "Hyperthyroidism in Pregnancy," Luis B. Curet, M. D., University of Wisconsin, Madison.

April 18 *Dept. of Radiology*: Melvin Clouse, M. D., Chairman, Department of Radiology, New England Deaconess Hospital, Boston.

*Dept. of Anesthesia*: One Thursday each month, 4 p.m.

*Dept. of Medicine*: Variable—incorporated in Grand Rounds

*Dept. of Family Practice*: Variable—incorporated in Grand Rounds

## Bluefield Ophthalmologist Receives Award

J. Elliott Blaydes, M. D., Bluefield eye physician, recently received the American Academy of Ophthalmology's Honor Award for outstanding service and contributions to his profession.

He was one of 30 Academy members and two nonmembers honored at the opening ceremonies of the Academy's five-day meeting in San Francisco.

J. Elliott Blaydes, M. D.

Doctor Blaydes, President of the Blaydes Foundation, was honored for his voluntary contributions to the Academy's continuing education program. The ophthalmologist has been Secretary-Treasurer of the West Virginia Academy of Ophthalmology and Otolaryngology for the past 15 years. An Associate Professor at Marshall University School of Medicine and Chief of Eye Surgery at St. Luke's Hospital in Bluefield, he is on the staffs of Bluefield Community and Princeton Community hospitals.

A Past President of the Mercer County Medical Society, the ophthalmologist is a former delegate member of the Southern Medical Association and Co-Chairman of the Committee on Industrial Safety for the Contact Lens Association of Ophthalmologists. He is a graduate of Princeton University, and received his M. D. degree in 1954 from the University of Pennsylvania Medical School, where he was President of the Undergraduate Medical Society. He completed his residency in ophthalmology as Chief Resident at the New York Eye and Ear Infirmary in 1958. He is certified by and is an associate examiner for the American Board of Ophthalmology.

## National Urology Lectureship Honors State Doctor

An annual lectureship to honor Charles A. (Carl) Hoffman, M. D., of Huntington has been established by the American Association of Clinical Urologists (AACU).

Doctor Hoffman, the first President of the AACU, was called the "guiding spirit" in its creation.

Charles A. Hoffman, M. D.

A Past President of the State Medical Association, Doctor Hoffman was President of the American Urological Association in 1967-68, and President of the American Medical Association in 1972-73.

The lectureship will be supported by a grant from Roche Laboratories. The first lecture will be delivered at the 1980 annual meeting of the AACU in San Francisco by Tom E. Nesbitt, M. D., third President of the AACU and current Past President of the AMA.

"Few men have achieved so remarkably in the service of community and country, college and calling," said the AACU.

## CME Accreditation Role Resumed By AMA

The American Medical Association has announced the formation of the Committee on Accreditation of Continuing Medical Education (CACME). The committee recently held its first meeting to review the 34 organizations and institutions applying for accreditation of their continuing medical education programs.

As physicians face an exploding technology and strive for cost-effective programs, continuing medical education takes an ever-increasing importance in our society, said the AMA. The AMA, through CACME, will meet the challenge of ensuring a high standard of CME programming by again assuming its singular responsibility for the national accreditation of organizations that offer CME to physicians.

In recognizing that the state medical societies are the most appropriate accrediting bodies within the states, the AMA House of Delegates has assured them of their continued responsibility for intrastate accrediting of CME institutions.

The AMA considers itself the leader in the field of accreditation for all levels of medical education for the past 75 years. In 1964, a program for accreditation of CME was first established and the AMA functioned by itself as a national accrediting agency. In 1977, the AMA formed, with six other professional organizations, the Liaison Committee on Continuing Medical Education (LCCME) and delegated to it the responsibility for accreditation.

After two years, the AMA House of Delegates reconsidered that delegation of responsibility and concluded that the differing educational philosophies of the sponsor organizations and the procedures of the liaison committee were not serving the best interests of practicing physicians. Furthermore, there were continuing efforts by committee members appointed by the other organizations to circumvent the original articles of agreement with respect to the establishment of policy, the AMA said.

## Eight Hospitals To Seek Rehab Planning Help

The number is eight, not six.

The number, that is, of hospitals in West Virginia interested in seeking some planning money from a 1979 legislative appropriation toward development of new medical rehabilitation facilities and services.

Oak Hill Hospital, and Cabell-Huntington Hospital in Huntington, must be added to those six institutions listed earlier in some Medical Association committee minutes as meeting a November 1 deadline with letters of intent to seek such funds.

Oak Hill and Cabell-Huntington easily were under the deadline wire. Because of the necessity for dividing secretarial responsibilities for handling such matters in the West Virginia Department of Health, they were not included on the earlier list available to the Association.

The hospitals have until February 1 to submit detailed planning grant requests, which then will be reviewed by a special steering committee.

Therefore, on July 25, 1979, the AMA decided to resume its own broad-based program of CME accreditation.

**West Virginia Accrediting Body**

The West Virginia State Medical Association —except during the two-year period when the AMA was part of the LCCME—has served as a CME accrediting body for the AMA since the Association began its program in 1973. (The Association's program of accrediting institutions and organizations in the state also continued uninterrupted during the two years the AMA was a part of the LCCME.)

The CACME draws its members from state and specialty medical societies, hospitals, medical schools, resident physicians, national organizations, and the public. The Chairman is Edward N. Brandt, Jr., M. D., of Austin, Texas.

# Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*One Hundred Years of Physiology at West Virginia University, 1869-1969*, by Edward J. Van Liere, Ph. D., M. D. 124 pages. Price $10. West Virginia University Foundation, Morgantown, West Virginia 26506. 1979.

*The Nervous System, 2nd Edition*, by William F. Ganong, M. D. 243 pages. Price $11. Lange Medical Publications, Los Altos, California 94022. 1979.

*Current Surgical Diagnosis and Treatment, 4th Edition*, by J. Englebert Dunphy, M. D., and Lawrence W. Way, M. D. 1162 pages. Price $19. Lange Medical Publications, Los Altos, California 94022. 1979.

*Understanding Hysterectomy: A Woman's Guide*, by F. G. Giustini, M. D.; and F. J. Keefer, M. D. (Introduction by Elizabeth B. Connell, M. D.). 166 pages. Price $7.95 (paper). Walker and Company, 720 Fifth Avenue, New York, New York 10019. 1979.

# Medical Meetings

Jan. 3-5—AMA Health Legislation Meeting, Phoenix, AZ.

Jan. 4-11—Am. Society of Clinical Pathologists, San Diego.

Jan. 12—AMA Conference on Medical Aspects of Sports, San Antonio.

Jan. 12-15—AMA Winter Scientific Meeting, San Antonio.

Jan. 18—Assn. for the Care of Asthma, Miami Beach.

Jan. 19-23—Am. College of Allergists, Miami Beach.

**Jan. 25-27—13th Mid-Winter Clinical Conference, Charleston.**

Jan. 27-Feb. 1—International Gastoenterol. & Family Practice Conference, Orlando, Fla.

Feb. 6-10—Am. College of Psychiatrists, San Antonio.

Feb. 7-12—Am. Academy of Orthopedic Surgeons, Atlanta.

Feb. 16-20—Am. Academy of Allergy, Atlanta.

March 9-13—Am. College of Cardiology, Houston.

March 19-21—Am. Society for Clinical Pharmacology & Therapeutics, San Francisco.

April 2-8—Am. College of Allergists, Washington, D. C.

April 10-11—W. Va. Chapter, Am. Academy of Pediatrics, Charleston.

April 17-18—Rural Health Conference, Boston.

April 17-20—Mo. State Med. Assn., Jefferson City.

April 18-20—Scientific Assembly, W. Va. Chapter, AAFP, Morgantown.

April 20-23—W. Va. Academy of Ophthalmol. & Otolaryngol., White Sulphur Springs.

April 21-25—Am. Roentgen Ray Society, Las Vegas.

April 28-30—Am. Assn. for Thoracic Surgery, San Francisco.

April 28-May 2—Am. Pediatric Society, San Antonio.

April 30-May 2—Med. & Chirurgical Faculty of the State of Md., Hunt Valley, Md.

May 1-3—W. Va. Chapter, ACS, White Sulphur Springs.

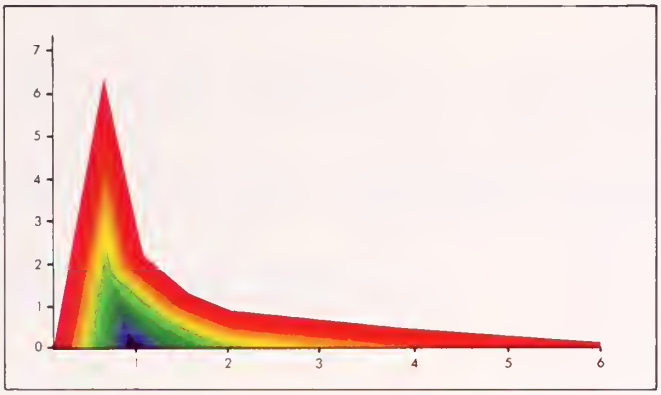
May 5-8—Am. College of Obstetricians & Gynecologists, New Orleans.

May 10-15—Ohio State Med. Assn., Cincinnati.

May 18-21—Am. Thoracic Society, Washington, D. C.

**Aug. 20-23—113th Annual Meeting, W. Va. State Assn., White Sulphur Springs.**

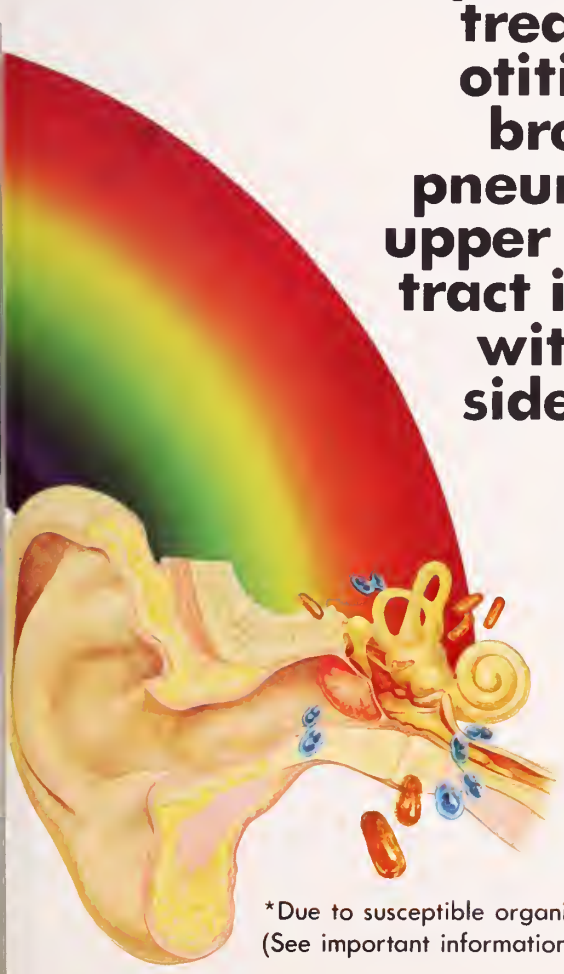
# more than just spectrum

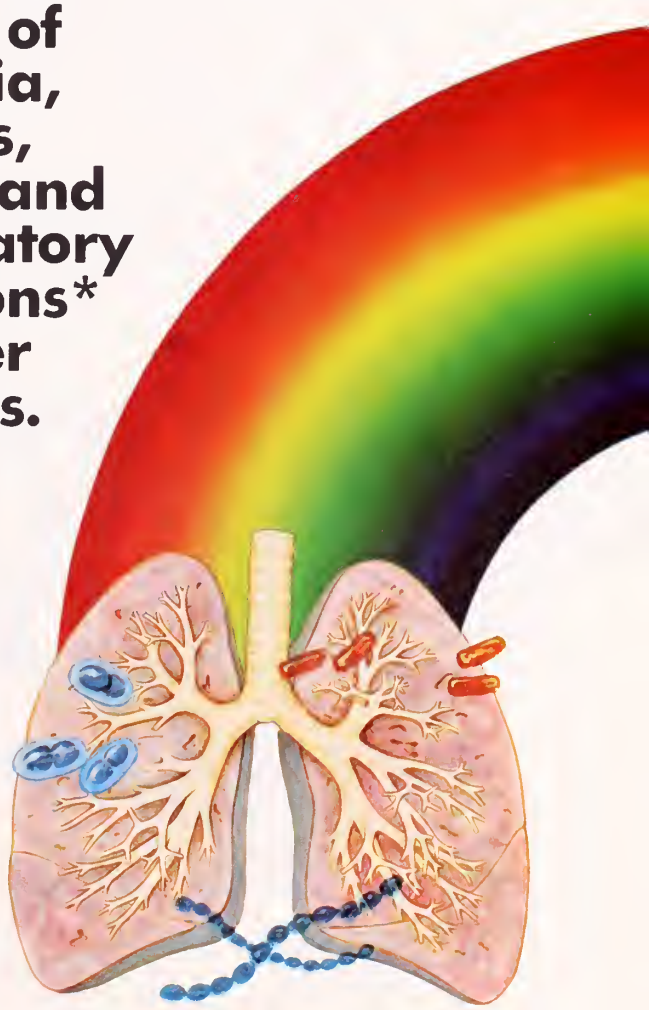



# New CYCLAPEN®

## (cyclacillin) Tablets/ Suspension

**Efficacy proven in the treatment of otitis media, bronchitis, pneumonia and upper respiratory tract infections* with fewer side effects.**





*Due to susceptible organisms
(See important information on last page.)

# New CYCLAPEN®
## (cyclacillin) Tablets/ Suspension

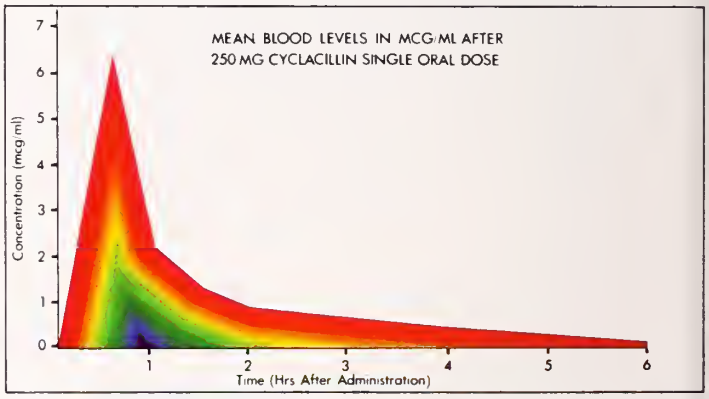
# efficacy with fewer side ampicillin confirmed in studies of 2,581

Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin




Clinical efficacy of CYCLAPEN® in otitis media†

| Causative Organism | | No. of Patients |
|---|---|---|
| *S. pneumoniae* | 96 | 82 |
| | 95 | |
| *H. influenzae* | 88 | 96 |
| | 85 | |

% Clinical Response
% Bacterial Eradication

## more than just spectrum in otitis media

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

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# effects than double-blind patients*

Fewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

| Total number of drug-related side effects in all patients | |
|---|---|
| CYCLAPEN® | 128 of 1,286 (10%) of patients |
| ampicillin | 202 of 1,129 (18%) of patients |
| Difference statistically significant ($P < 0.001$) | |

CYCLAPEN® (cyclacillin)
Effective for otitis media† in children

- Excellent clinical results in eliminating the two most common causative organisms in otitis media
- Significantly lower incidence of diarrhea and skin rash in children treated with CYCLAPEN® Suspension

| | diarrhea | rash |
|---|---|---|
| CYCLAPEN | 9.1% | 2.1% |
| ampicillin | 19.2% | 5.8% |
| | $P < 0.001$ | $P < 0.03$ |

## In bronchitis, pneumonia and upper respiratory tract infections†

| High cure rate with CYCLAPEN® | | |
|---|---|---|
| Causative Organism | Bronchitis/Pneumonia† | No. of Patients |
| *S. pneumoniae* | 100 / 95 | 73 |
| Chronic Bronchitis† (acute exacerbation) | | |
| *H. influenzae* | 92 (Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*) | 12 |
| Streptococcal Sore Throat† | | |
| Group A beta-hemolytic Streptococcus | 100 / 86 | 44 |
| % Clinical Response / % Bacterial Eradication | | |

# more than just spectrum CYCLAPEN®

(cyclacillin) Tablets/ Suspension


1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.
2. Data on file, Wyeth Laboratories.


(See important information on next page.)

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New from Wyeth Laboratories

# CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Usual children's dosage: 50 to 100 mg/kg/day in equally spaced doses, depending on severity.

## more than just spectrum in otitis media, bronchitis, pneumonia, and upper respiratory tract infections*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

### How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

**Indications**

*Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.*

Cyclapen® is indicated for the treatment of the following infections

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis* (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

**Contraindications**

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

**Warnings**

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN. ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

**Precautions**

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

**Adverse Reactions**

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

**Dosage and Administration**

| INFECTION* | ADULTS | CHILDREN |
|---|---|---|
| | | Dosage should not result in a dose higher than that for adults |
| *Respiratory Tract* | | |
| Tonsillitis & Pharyngitis** | 250 mg q.i.d. in equally spaced doses | body weight <20 kg (44 lbs): 125 mg q.i.d. in equally spaced doses<br>body weight >20 kg (44 lbs): 250 mg q.i.d. in equally spaced doses |
| Bronchitis and Pneumonia | | |
| Mild or Moderate Infections | 250 mg q.i.d. in equally spaced doses | 50 mg/kg/day q.i.d. in equally spaced doses |
| Chronic Infections | 500 mg q.i.d. in equally spaced doses | 100 mg/kg/day q.i.d. in equally spaced doses |
| *Otitis Media* | 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity | 50 to 100 mg/kg/day in equally spaced doses depending on severity |
| *Skin & Skin Structures* | 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity | 50 to 100 mg/kg/day in equally spaced doses depending on severity |
| *Urinary Tract* | 500 mg q.i.d. in equally spaced doses | 100 mg/kg/day in equally spaced doses |

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

*Patients with Renal Failure*

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive two doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of <10 ml/min or serum creatinine values of >10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

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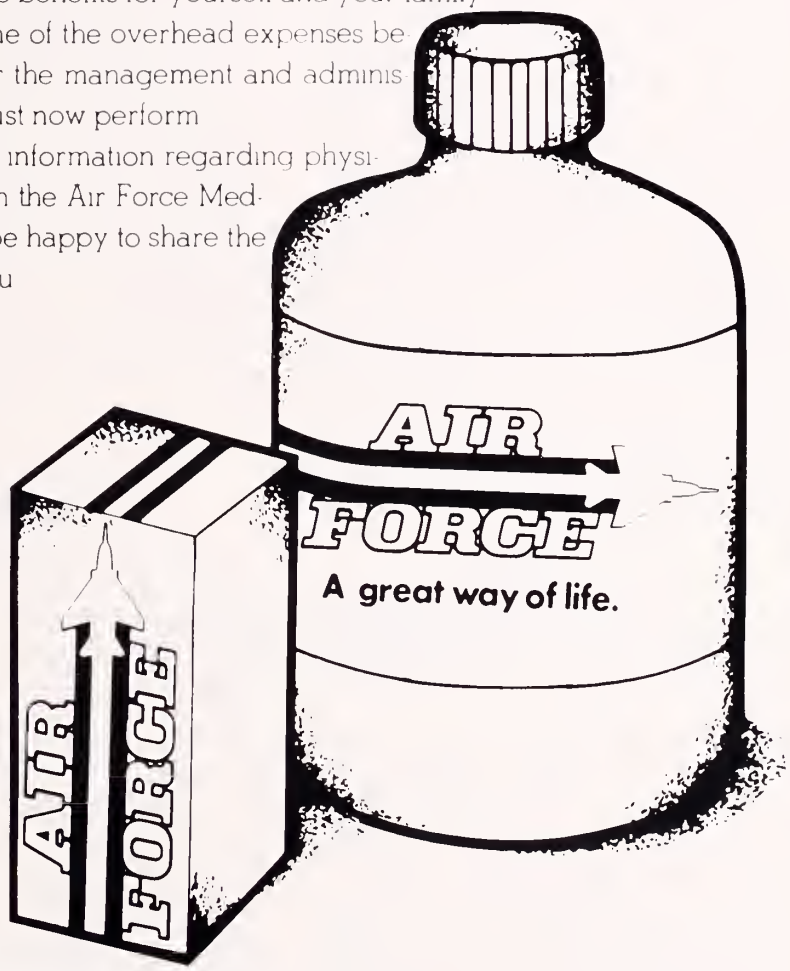


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# WVU Medical Center —News—

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## How Much Childbirth Pain Relief Is Safe?

Despite the fact that local or epidural injections have replaced general anesthesia as the recommended agent for childbirth, controversy still flourishes concerning the use of any drugs during labor and delivery.

The question remains: How much pain relief is possible for the mother without harm to the child?

Although convincing arguments are cited by both sides, varying interpretations of data and lack of conclusive scientific evidence have left the question unresolved.

An ongoing research project funded for $122,-790 at WVU Medical Center may supply some basic answers. While it will not establish either short or long-terms effects of local anesthesia on the fetus, it will build a foundation for further research by providing data on the uptake and distribution of local anesthetics in the unborn.

### Answers to Questions

Principal investigator for the project is Roland L. Kennedy, M. D., Professor of Anesthesiology in the School of Medicine. Doctor Kennedy is also Director of Obstetrical Anesthesia at University Hospital.

The project is funded for two years by the National Institute of Child Health and Human Development.

Through research on pregnant ewes, Doctor Kennedy and his associates hope to establish answers to the following questions:

How much local anesthesia used during labor or delivery for pain relief in the mother gets to the fetus? What is its rate of absorption? Where does it go? What is the correlation of animal studies to drug concentrations found in human maternal and newborn blood samples?

"We will be looking at a variety of local anesthetics used both in vaginal delivery and cesarean section," Doctor Kennedy said. "Each one has different properties which may shed more light on the total uptake and rate of absorption by the fetus. In addition, we will be examining human blood—both fetal and maternal—to determine plasma-protein binding for these drugs.

"We will analyze the distribution of the drugs to the vital organs such as the brain, heart, kidneys, lungs and liver to determine where the main effects might be expected.

"These studies will enlighten us on some fundamental concepts of drug uptake in the fetus, not only for local anesthetics but essentially for many other drugs also."

Doctor Kennedy's research associates include John U. Bell, Ph. D. Assistant Professor of Pharmacology, and Dinesh M. Doshi, M. D.; Frank Zavisca, Ph. D., M. D.; Robert Bettinger, M. D., and Yadin David, M. S., assistant professors of anesthesiology.

## Two Doctors Receive SMA Grants

Two WVU physicians have received Southern Medical Association research grants for medically-relevant studies which eventually might expand treatment capabilities.

Drs. Gregory S. Carter, resident in neurology, and Frank L. Schwartz, instructor of surgery, are among the 36 1979 SMA grant recipients from 17 states and 23 different institutions.

By working with isoenzymes of monamine oxidase, a key enzyme in the brain, Doctor Carter hopes to gain insight into possible treatments for Parkinson's disease and psychiatric disturbances. He is a 1975 graduate of the WVU School of Medicine from Morgantown.

Doctor Schwartz, a 1978 WVU School of Medicine graduate from Parkersburg, is studying the interaction of androgens with glucocorticoids and looking at steroid receptor mechanisms in an attempt to define androgen's protein anabolic effect in other tissues.

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# Third-Party News, Views and Program Concerns

## Administration Pursuing Medicaid Reforms

State-by-state variations in Medicaid coverage have prompted the Administration to assign high priority to upgrading Medicaid and to move toward making benefits and eligibility uniform across the nation, the American Medical Association reports. Despite the estimated $20 billion plus cost of Medicaid during the past fiscal year, serious gaps remain in financing health care services for the poor. One result has been that hospitals and physicians are providing more than $1 billion a year in charity care, according to the AMA.

The Administration, whose Medicaid reforms are embodied in its National Health Plan, has insisted that the Medicaid problem be recognized by the Senate Finance Committee during its mark-up of a Catastrophic National Health Insurance bill. Responding to the plea, the Committee tentatively has approved provisions insuring that the proposed $3,500 "deductible" for out-of-pocket health care expenses be lowered depending upon income.

From 25 per cent to 35 per cent of the population with incomes below the poverty line—some nine million people—don't qualify for Medicaid. In some states more than 70 per cent of the poor are not covered. The differing welfare programs in the states and the need for Medicaid to mesh with these had posed a giant headache. Federal matching Medicaid funds are only furnished for coverage of people who fit specific welfare categories.

There are large loopholes. For example, single adults and childless couples who are poor cannot receive Medicaid unless they are disabled or are more than 65 years old.

Income cutoffs for Medicaid eligibility vary greatly, from less than $2,400 for a family of four in some southern states to $4,800 or above in some northern tier states.

A significant problem is the discouragement to providers stemming from the Medicaid payment rates which average 20 to 25 per cent lower than Medicare's rate, a bargain-basement rate, itself.

## FDA Establishes Sunlamp Safety Standards

The Food and Drug Administration recently required that sunlamps include warning labels, goggles, timers and other controls to protect users from radiation injuries due to overexposure.

More than 7,700 persons were treated in hospital emergency rooms in the United States in 1978 for sunlamp-related injuries, according to the Consumer Product Safety Commission. Most of the injuries were skin burns and eye irritation. Repeated exposure to ultraviolet radiation may cause premature skin-aging and skin cancer.

The safety standard applies to sunlamps manufactured after May 6, 1980, and requires each lamp to have: a timer that would automatically turn off the lamp after 10 minutes or less of operation; a manual switch so the lamp can be turned off by the user; a special base for the sunlamp bulb so it cannot be used in a regular light socket; and enough protective goggles so that the maximum number of people recommended can use the lamp safely at the same time.

Jere E. Goyan, Commissioner of Food and Drugs, said:

"This standard will require sunlamps to have certain design features that will make them safer to use. It also requires that sunlamp users be provided with the information they need to use these products safely. But, as with many products, safe use ultimately is up to the consumer. To get maximum benefit from sunlamps at minimum risk, consumers should read the directions and warnings carefully and take the necessary precautions to avoid overexposure."

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- ☐ LOW-COST LIFE INSURANCE
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- ☐ $100,000 ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
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  Pays your office expense up to $3,500 per mo. while you are disabled
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  Covers: Malpractice — Home — Personal — Auto Liability

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# Obituaries

### WILLIAM E. McNAMARA, JR., M. D.

Dr. William E. McNamara, Jr., Wheeling surgeon, died on November 15 in a hospital there. He was 57.

A native of Wheeling, he was graduated from Washington & Jefferson College and received his M. D. degree in 1946 from Western Reserve University. He served his internship and residency at Lakeside University Hospital of Cleveland.

Doctor McNamara was a member of the Ohio County Medical Society and the West Virginia State Medical Association.

* * *

### J. FOSTER CARR, M. D.

Dr. J. Foster Carr, Huntington internist, died on November 28 in a hospital there. He was 62.

Doctor Carr was a member of the Cabell County Medical Society and the West Virginia State Medical Association.

A native of Princeton, he was graduated from West Virginia University and received his M. D. degree in 1944 from the Medical College of Virginia.

He served his internship and residency at the former Chesapeake and Ohio Hospital in Huntington.

Survivors include the widow; a daughter, Dr. Linda G. Carr of Nashville, Tennessee, and a son, Joel Foster Carr II of Huntington.

* * *

### ANGELO S. DANIEL, M. D.

Dr. Angelo S. Daniel, Wheeling surgeon, died in a hospital there on November 26. He was 56.

Doctor Daniel was a Fellow of the American College of Surgeons, and a member of the Ohio County Medical Society, West Virginia State Medical Association, American Medical Association, and Southeastern Surgical Congress.

He served as a surgeon with the U. S. Navy from 1951 to 1953, and was Secretary of the Ohio County Medical Society in 1967-68.

A native of Wheeling, Doctor Daniel was graduated from Bethany College and received his M. D. degree in 1947 from Johns Hopkins University School of Medicine.

He interned at Church Home and Hospital in Baltimore, and completed his residency at the University of Pittsburgh.

Survivors include the widow; a brother, Mayor John S. Daniel of Bethlehem (Ohio County), and a sister, Mrs. Harold B. Thomas of St. Clairsville, Ohio.

## Americans Run For Their Lives In 1979

Americans ran for their lives in 1979.

And they played tennis. And racquetball. And swam many laps in the pool. And roller skated.

The 1970s trend toward regular exercise and better physical fitness peaked in the final year of the decade. Tens of millions of Americans were exercising more or less vigorously and more or less regularly. This definitely did more good than harm, the American Medical Association has observed.


**FAMILY PRACTICE PHYSICIAN AND DENTIST**

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# County Societies

### FAYETTE

The Fayette County Medical Society met on November 7 at Montgomery Hospital.

Guests were Dr. Stephen D. Ward of Wheeling, President of the State Medical Association, and Mr. Tom Auman of Charleston, Account Supervisor for Aetna Life and Casualty, the State Medical Association's carrier for malpractice insurance.

Doctor Ward said he was especially concerned that only 61 per cent of the physicians in the state belong to the AMA. He also discussed a new state Medical Practice Act which the State Association is trying to develop at this point.

Mr. Auman discussed malpractice insurance rates and, also, a new concept of risk management which will be developed soon.—Lewis A. Cook, M. D., Secretary.

* * *

### MARION

The Marion County Medical Society met on November 27 at the Fairmont Field Club.

Dr. Donald W. Cox, Associate Professor of Obstetrics and Gynecology at West Virginia University Medical Center in Morgantown, was the guest speaker. He discussed indications for pelvic surgery.—William L. Mossburg, M. D., Secretary.

* * *

### McDOWELL

Dr. Stephen D. Ward of Wheeling, President of the State Medical Association, was the guest speaker for the November 14 meeting of the McDowell County Medical Society.

Doctor Ward talked on politics and medicine, urging more doctors to become members of the AMA and contributors to WESPAC.

New officers were elected, with Dr. Cheryl Lynn Linkous being named President. — Muthusami Kuppusami, M. D., Secretary.

* * *

### CABELL

The Cabell County Medical Society met on November 8 at the Gateway Motel in Barboursville.

Dr. Thomas P. Gibson of Northwestern University School of Medicine in Chicago, the Pfizer visiting professor in clinical pharmacology, was the guest speaker.

Doctor Gibson discussed the effect of altered renal function on drug metabolism.—Charles E. Turner, M. D., Secretary.

## ACS Meets March 23-27 In Toronto

The 8th annual spring meeting of the American College of Surgeons will be held in Toronto, Canada, March 23-27 at the Sheraton Centre Hotel.

The following postgraduate courses for physicians will be offered: No. 1—Surgical Problems of the Stomach and Duodenum; No. 2—Infection and Altered Immune Response in Surgical Patients; No. 3—Gynecologic Surgical Techniques; No. 4—Trauma to the Eye and Its Adnexae; No. 5—Problems in Vascular Disease; No. 6—Surgical Nutrition; No. 7—Current Concepts and Controversies in Breast Cancer, and No. 8—Lower Abdominal and Pelvic Malignancies.

The meeting also will include panel discussions on "Hiatal Hernia" and "Surgical Jaundice" and a lecture on "Selective Shunts for Portal Hypertension" by W. Dean Warren, M. D., Whitehead Professor and Chairman of the Department of Surgery, Emory University School of Medicine in Atlanta.

Registration at the spring meeting is free for Fellows of the College whose due are paid for 1979, and for participants in the Candidate group. The registration fee for non-Fellows is $80. Physicians in the full-time federal service and surgical residents (with a letter verifying their residency status) pay $40. All participants who enroll in postgraduate courses must pay appropriate fees for the courses selected.

Postgraduate courses are open to medical doctors only. Properly identified nurses, medical students, allied health personnel and spouses may attend the general sessions at no charge.

The deadline for advanced registration is February 29. Advanced registration forms may be obtained from Mr. Frank Arado, American College of Surgeons, 55 E. Erie Street, Chicago, Illinois 60611.

As an organization accredited for continuing medical education, the American College of Surgeons designates that the continuing medical education offerings of the spring meeting meet the criteria for hour-for-hour credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

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**PHYSICIANS NEEDED**—Family practice doctors, or internist needed for city or rural practice. Population approximately 65,000. Contact Mrs. Leona Willard, Chairwoman, Task Force for the Recruitment of Doctors, 4 Bonasso Drive, Fairmont, WV 26554. Telephone: (304) 363-7863.

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**PSYCHIATRIST WANTED**—To fulfill the critical need in West Virginia Mental Institutions. Qualification: Board eligibility, with a desire to become Board Certified. MUST BE DEDICATED, ability to take the initiative, be productive, and work harmoniously with all personnel. Starting salary $40,000. Contact Arthur Schultz, Professional Services Coordinator, State Health Department, 1800 Washington Street, East, Charleston, WV 25305.

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**WANTED**—Physician to fulfill the critical needs in West Virginia's State Institutions. Qualification: A permanent license to practice medicine in West Virginia and three years of full-time paid experience. Starting salary $40,000. Contact Arthur Schultz, Professional Services Coordinator, State Health Department, 1800 Washington Street, East, Charleston, WV 25305.

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**RADIOLOGIST WANTED** — Temporary salaried position, minimum six months with possibility for extended employment if mutually satisfactory. Multi-hospital private practice, malpractice insurance paid, salary negotiable. Eligibility for Virginia license required. Curriculum vita first letter, please. Reply to FBC, P. O. Box 1031, Charleston, WV 25324.

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**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician for 9 year old modern 80 bed hospital centrally located between Parkersburg and Charleston. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician for a modern 95-bed hospital. New emergency room facilities recently built. Excellent working conditions. Contact Patrick Smith, Assistant Administrator, Summers County Hospital, Hinton, WV 25951. Telephone: (304) 466-1000.

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**WANTED**—Board eligible or certified Obstetrician/Gynecologist needed for small town of 6,000. Modern hospital with latest equipment to work with available. Financial arrangements and office space negotiable. Contact J. N. Vallandingham, Administrator, Summers County Hospital, Hinton, WV 25951. Telephone: (304) 466-1000.

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**WANTED**—Board eligible or certified Orthopedic Surgeon needed for small rural community. Modern hospital to work in with clinic building located next to hospital. Financial arrangements and office space negotiable. Contact J. N. Vallandingham, Administrator, Summers County Hospital, Hinton, WV 25951. Telephone: (304) 466-1000.

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**WANTED**—Physicians for growing northeastern West Virginia community with drawing population over 100,000. Excellent office facility complete with laboratory and radiology. Modern hospital nearby. Guaranteed income. Contact C. L. Dana, The W. Va. Medical Journal, P. O. Box 1031, Charleston, WV 25324.

**WANTED** — Obstetrician/Gynecologist needed to take over existing practice in progressive community centrally located between Parkersburg and Charleston. Nine year old modern 80 bed hospital with latest equipment and facilities. Hospital is willing to negotiate financial arrangements and office space. Excellent opportunity for young physician wishing to establish active practice. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

**FAMILY PRACTICE OPENINGS** — Pendleton County offers the rural medical practice challenge you are seeking. Located in the picturesque Eastern Panhandle town of Franklin are a group of active and interested businessmen and citizens committed to recruiting and financially supporting the establishment of new practices. This opportunity is worth exploring! Contact George I. Sponaugle, President of Pendleton Industries, Franklin, WV 26807. Telephone: (304) 358-2337.

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Eye & Ear Clinic of Charleston, The xv

Golden Clinic, The xv

Harding Hospital, The xx

Lilly, Eli, and Company Insert

McDonough Caperton Shepherd Association Group xiii

Merck Sharp & Dohme Insert

Myers Clinic, The xvi

Pathology Associates Laboratory v

Prince Medical Reference Laboratories xi

Roche Laboratories ii, Inside Back Cover, Back Cover

Smith Kline & French Company Insert

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**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

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**Dosage: Not recommended for infants less than two months of age.**

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Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

*Children two months of age or older.*

| Weight | | Dose—every 12 hours | |
|---|---|---|---|
| lbs | kgs | Teaspoonfuls | Tablets |
| 20 | 9 | 1 teasp. (5 ml) | ½ tablet |
| 40 | 18 | 2 teasp. (10 ml) | 1 tablet |
| 60 | 27 | 3 teasp. (15 ml) | 1½ tablets |
| 80 | 36 | 4 teasp. (20 ml) | 2 tablets or 1 DS tablet |

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|---|---|
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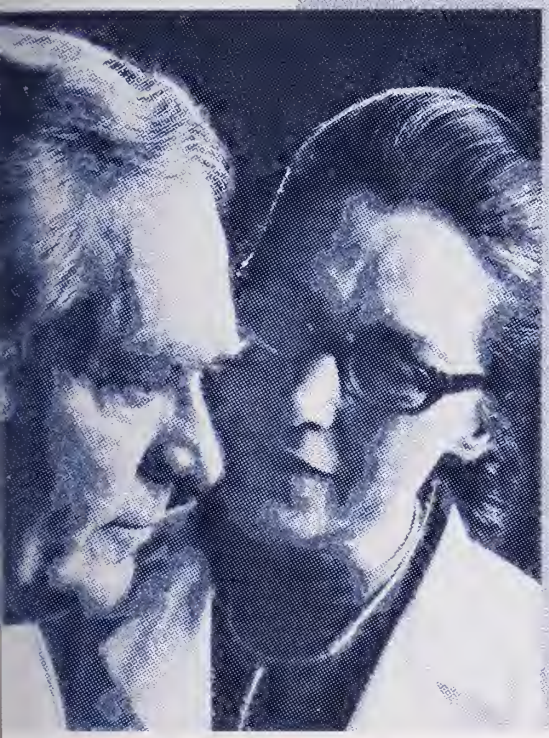

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Please see next page for summary of product information.

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# The West Virginia Medical Journal

*Official Publication of the West Virginia State Medical Association*

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**MEMBER, WEST VIRGINIA PRESS ASSOCIATION, 1980**

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# CONTENTS

## Scientific Articles

A Case of Recurrent Boerhaave's Syndrome—George F. Kish, M. D.; and Floyd A. Katske, M. D. 27

Epididymal Tumors: A Case Report—Ahmed H. Kalla, M. D.; Robert P. Cricco, M. D.; and Bradford M. McCuskey, M. D. 31

Hemostasis In Suprapubic Prostatectomy Utilizing Gelfoam Cone—Gregory J. Post, M. D.; and Joseph Kassis, M. D. 33

Gastric Distress Evoked By Anti-Inflammatory Drugs—John C. Krantz, Jr., M. D. 37

## The President's Page

The Hard Sell—Stephen D. Ward, M. D., President, W. Va. State Medical Association 38

## Editorials

Education 39

Occurrence and Claims-Made 39

A Checklist for Cost Control 40

## General News

JAMA Editor to Address Annual Meeting 42

Continuing Education Activities 43

AMA House Actions 44

State AAFP Chapter Meeting in April 46

Dr. Justus C. Pickett Rejoins WVU Faculty 47

Review A Book 48

## Special Departments

WVU Medical Center News xiv

Third-Party News, Views, Program Concerns xvi

Obituaries xviii

County Societies xix

Classified Section xxvi

Index To Advertisers xxviii

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**FOR INFORMATION CALL (704) 554-0285**

The West Virginia Medical Journal

Vol. 76, No. 2 February, 1980

# A Case Of Recurrent Boerhaave's Syndrome

GEORGE F. KISH, M. D.
*Assistant Professor of Surgery, West Virginia University Medical Center, Morgantown*

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*In 1974, a 51-year-old white male underwent left thoracotomy and primary repair of a left-sided spontaneous esophageal rupture. Approximately 14 months later, he was readmitted and right-sided esophageal perforation was diagnosed and repaired via right thoracotomy. This is apparently the first reported case of recurrent spontaneous esophageal perforation. A historical review, the clinical features, and various modalities of therapy are presented.*

SPONTANEOUS perforation of the esophagus is an infrequently-seen problem often posing difficulty in diagnosis and management. Since it was first reported by Hermanno Boerhaave in 1724,[1] approximately 300 cases have appeared in the literature. Pathological studies, physiological measurements, clinical course and unusual presentations have all been described. Although the most common therapy is layered closure, ingenious methods of bypassing, draining or otherwise controlling the leak have been reported.[2,3,4] The case presented is the first that we know of to involve a recurrent spontaneous rupture.

### Case Report

In July, 1975, a 51-year-old white, alcoholic male underwent partial right upper lobectomy and talc peudrage because of injuries sustained in an auto accident. In September, 1975, he was admitted to the Washington Veterans Administration Hospital with no history, severe respiratory distress and a large left pleural effusion. A chest tube was inserted and gastric fluid drained. Orally-administered methylene blue confirmed the diagnosis of esophageal perforation. He underwent left thoracotomy and primary repair of a three-centimeter, supradiaphragmatic tear using Dacron sutures. He became septic and developed an esophago-pleural fistula (Figure 1). This

**Figure 1. Barium swallow showing esophago-pleural fistula following primary repair of left-sided esophageal perforation.**

closed with the aid of IV hyperalimentation and he was discharged in January, 1976.

In November, 1976, the patient was admitted through the Emergency Room of the George Washington University Hospital complaining of right upper quadrant abdominal pain and severe respiratory distress. Admission chest x-ray showed a right pneumothorax and loculated pleural effusion. A Gastrograffin swallow was performed and demonstrated an esophago-pleural fistula on the right (Figure 2); consequently, a chest tube was inserted. Because the patient had had a previous right thoractomy and the loculated effusion appeared to be separated from the chest wall by lung, it was felt that adequate drainage could not be established without thoracotomy. Therefore, the patient was stabilized and taken to the operating room approximately 20 hours after admission. The right lung was densely adhesed to the chest wall and diaphragm, and there were multiple pockets of purulent/gastric fluid. A six-centimeter, right supradiaphragmatic perforation was closed in two layers as the tissue planes were easily defined. The left side of the esophagus was scarred and attached to the pleura and left hemidiaphragm and could not be mobilized. During the procedure the aorta was inadvertently torn. This was repaired with vascular sutures over teflon pledgets and separated from the esophagus by a pleural flap. The initial course was uncomplicated and the patient was extubated on the second postoperative day.

**Figure 2. Gastrograffin swallow illustrating loculation of contrast material in chest following right-sided esophageal tear.**

Cultures taken during surgery grew Serratia and Proteus for which appropriate antibiotics were given. On the morning of the tenth postoperative day, the patient had a sudden massive hemorrhage through the right chest tube and expired. Permission for autopsy was denied.

### Comments

Boerhaave's syndrome, or "Atraumatic panmural rupture of the esophagus," was first described in a 70-page monograph published in 1724 by Dr. Hermanno Boerhaave.[1] In this monograph, Boerhaave described a case of esophageal tearing secondary to self-induced emesis after a gluttonous meal. The patient, Baron deWassenaer, the Grand Admiral of Holland, had consumed a large dinner (Table), developed discomfort, took an emetic and gagged himself with a feather. This caused explosive vomiting followed by severe epigastric and anterior chest pain. Boerhaave described the patient as sitting in bed, his body doubled over, requiring two servants to support him. He noted that the Baron suffered severe pleuritic chest pain every time that he regurgitated.

Doctor Boerhaave diagnosed an esophago-gastric obstruction and treated him with "sweet

**TABLE**

**Dinner Menu of Grand Admiral of Holland.**

BARON de WASSENAER'S DINNER MENU
1723

VEAL SOUP with HERBS
BOILED LAMB and CABBAGE
FRIED SWEETBREAD and SPINACH
DUCK
TWO LARKS
COMPOTE of APPLES
DESSERT
PEARS, GRAPES, SWEETMEATS

BEER and MOSELLE

Reference: Boerhaave, H. (1724) *Atrocis nec descripti prius, Morbi Historia.*

almond oil;" however, the subsequent emesis was devoid of the oil. Approximately 19 hours after the initial attack, the patient expired. Boerhaave himself performed the autopsy and found pieces of duck and almond oil in the pleural space in addition to a large esophageal perforation.

The history and physical findings of esophageal perforation are classically described by Boerhaave. The pain is usually severe and unrelenting, often radiating to the neck, arms or back. It is worsened by swallowing, regurgitation or eructation. Swallowing may often be accompanied by coughing, indicating that a communication exists between the esophagus and the pleural space.[5] Physical examination characteristically shows a middle-aged male in severe distress, often sitting or leaning forward. Subcutaneous emphysema may be present over the sternum and in the suprasternal notch. Auscultation over the anterior chest may reveal Hamman's Sign of mediastinal emphysema.

The differential diagnosis of Boerhaave's syndrome must include myocardial infarction, a perforated gastric or duodenal ulcer, dissecting aortic aneurysm, pulmonary embolism or perforated lower abdominal viscus.

Diagnosis of Boerhaave's syndrome is best made radiographically. Subcutaneous and mediastinal emphysema are present along with hydro-pneumothorax. Naclerio had described a radiographic, "V"-shaped linear density in the facial planes of the mediastinal and diaphragmatic pleura in the region of the lower esophagus, and behind the heart.[6] However, this sign is often obliterated if there is a delay getting films because the emphysema becomes more extensive and involves the entire mediastinum.

### Fluid in Pleural Space

Ninety per cent of the patients have fluid in the pleural space. Contrast studies of the esophagus are diagnostic in only 75 per cent of cases. Van Heerdan has postulated that the radiopaque material is either too viscous or passage too rapid to extravasate.[7] In addition, the laceration may be occluded by edema or food particles.

In 1956, Derbes and Mitchell published an extensive report detailing the history, physical findings, pathologic anatomy and therapy of Boerhaave's syndrome.[8] They mathematically analyzed the stress placed on the esophagus and reasoned that a longitudinal tear should occur in the left distal supradiaphragmatic position by virtue of its having the least support of muscle and surrounding structures.

Only 32 years ago, Barrett reported the first successful closure of a spontaneous esophageal tear.[9] Since then the majority of reports emphasize early diagnosis and prompt surgical intervention, usually with standard two-layer closure. Poor blood supply, lack of serosal covering, and absence of omentum and friable submucosa often lead to breakdown of the suture line with subsequent empyema and fistula formation.

In 1975, Larrieu and Kieffer described a patient who survived esophageal perforation without closure or drainage.[10] They postulated that no contamination of the mediastinum or pleural cavities had occurred because the esophageal tear itself adequately decompressed the abscess pocket.

### Prompt Recognition Key Factor

Lyons *et al.* have reported a series of perforations of the esophagus, concluding that major surgical repair is often unnecessary.[11] Of 31 patients in the group, 13 developed spontaneous perforation, 13 were perforated by instrumentation and the remainder, secondary to various causes. In those with spontaneous perforation who underwent primary repair, the survival rate was 63 per cent. Of those who underwent drainage and/or gastrostomy, survival was 100 per cent. They concluded that "prompt recognition" was the key factor in survival and that drainage was necessary only if pleural contamination was present. However, most recent authors concur that esophageal perforation is a surgical emergency with mortality a function of time delay between occurrence and operation.

In the case presented, death undoubtedly resulted from a breakdown of the aortic repair. Because of the past history of esophageal perforation as well as the patient's clinical history, recurrent perforation was not suspected. Rather, aspiration pneumonia with abscess/empyema was diagnosed, causing a delay in appropriate therapy. Initial dissection was quite difficult because of the previous talc peudrage, and many undrained pockets were found between adhesions. When the esophagus was visualized the tear was quite easily seen and the tissue layers were in a surprisingly viable state. The edges were debrided and good bleeding resulted: therefore, interrupted, primary closure was performed.

During the procedure, thought was given to exclusion of the esophagus with cervical esophagostomy and gastrostomy as advocated by Urschel.[2] However, because of the previous left-sided perforation and resultant scar formation, it was felt that the dissection required to free up

the distal esophagus for ligation might result in more extensive tearing or possible hemorrhage. For the same reason, fundoplication, such as advocated by Symbas *et al.*,[4] was felt to be impossible in this situation. Because the tissues looked viable and a primary closure seemed possible even with the long delay, T-tube drainage, as described by Abbott, was thought to be unnecessary.[3]

In retrospect, when the tear in the aorta occurred it should have been excluded and axillary-femoral bypass performed. Closure with a pleural patch for protection simply was not adequate in the contaminated setting.

At the time of death, the patient was receiving intravenous hyperalimentation and was recovering. Unfortunately, autopsy was not permitted; therefore, adequacy of esophageal healing was not determined.

**References**


1. Boerhaave H: Atrocis nec descripti prius, Marbi Historia. Secundum Medeciae Artis Leges Concripta, Lugduni Btavorum. Boutesteniana, Medici, 1724.

2. Urschel HC Jr, Razzuk MA, Wood RE *et al.*: Improved management of esophageal perforation: exclusion and diversion in continuity. *Ann Surg* 179:587-591, 1974.

3. Abbott OA, Mansour KA, Logan WD Jr *et al.*: Atraumatic so-called "spontaneous" rupture of the esophagus. A review of 47 personal cases with comments on a new method of surgical therapy. *J Thorac Cardiovas Surg* 59:67-83, 1970.

4. Symbas PN, Hatcher CR Jr, Harlaftis N: Spontaneous rupture of the esophagus. *Ann Surg* 187:634-640, 1978.

5. Callaghan J: The Boerhaave syndrome (spontaneous rupture of the oesophagus). *Br J Surg* 59:41-44, 1972.

6. Naclerio EA: The "V sign" in the diagnosis of spontaneous rupture of the esophagus (an early roentgen clue). *Am J Surg* 93:291-298, 1957.

7. van Heerden JA, Toxopeus M, Troxel G: Boerhaave's syndrome. A case report. *Virg Med Mo* 101:452-457, 1974.

8. Derbes VJ, Mitchell RE Jr: Rupture of the esophagus. *Surg* 39:688-711, 865-888, 1956.

9. Barrett NR: Report of a case of spontaneous perforation of the esophagus successfully treated by operation. *Br J Surg* 35:216-218, 1947.

10. Larrieu AJ, Kieffer R: Boerhaave syndrome: Report of a case treated non-operatively. *Ann Surg* 181:452-454, 1975.

11. Lyons WS, Seremetis MG, DeGuzman VC, Peabody JW Jr: Ruptures and perforations of the esophagus: The case for conservative supportive management. *Ann Thor Surg* 25:346-350, 1978.


## Treatment As Well As Drugs

Drugs are useful to help hyperactive boys maintain control, but the combination of medication with psychological treatment brings an unexpectedly good outcome.

Stimulant medications help tremendously for the short term while the child continues to take the pills regularly, but medications alone provide an extremely poor outcome for the long term, according to a report in a recent issue of an American Medical Association specialty journal, *Archives of General Psychiatry*.

# Epididymal Tumors: A Case Report

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*A 1.6-centimeter, right-sided unilateral cystic swelling in the head of the epididymis was found in a 42-year-old white male. Histology showed a benign papillary cystadenoma.*

*Reports of epididymal tumors have been very uncommon: they have been mostly case reports or reviews with additional cases.*[1,3,6] *This paper describes a case of primary benign tumor of the epididymis and reviews the literature. The controversy regarding secondary neoplasms will not be discussed.*[2,4,5,6,7,8]

A 42-year-old white male presented with a painless, right-sided testicular mass of one year's duration. He was otherwise in good health and no abnormalities were detected. Physical examination showed a round, firm, smooth, non-tender, mobile mass occupying the upper pole of the right testicle approximately three-by-three centimeters in size. Following admission to the hospital, the patient underwent right scrotal exploration and a cystic mass of the head of the epididymis was completely excised.

### Pathology

*Gross Exam*: The specimen consisted of a cystic structure measuring 1.6 centimeter in diameter, encapsulated with a smooth, greyish surface and containing dark, brownish, bloody material.

*Cut Section*: This showed a thin wall which was easily separated from the coagulated material.

*Microscopic*: The cystic structure had a fibrovascular connective tissue wall and was lined by low columnar-to-cuboidal cells arranged in a single layer with occasional papillary projections into the lumen. These papillae were lined by a few layers of cuboidal cells and a scanty amount of connective tissue. These cells were hyperchromatic and varied in size with basally-located nuclei and vaculated cystoplasms. The lumen contained hemorrhagic material. There was no evidence of malignancy.

### Discussion

A review of the literature revealed only 40 cases[5,1,3] of papillary cystadenoma of the epididymis reported to date. Papillary cystadenomas of the globus major develop within the duct system of ductuli efferentes and are the only tumors of the epididymis which preserve their purely epithelial character.[5,9]

When this tumor occurs bilaterally (15 per cent)[9] it is frequently associated with Von Hippel-lindau's disease; while the unilateral and isolated cases of papillary cystadenoma of the epididymis have been regarded as a formfruste of the disease.[5,1,3]

Other benign tumors of the epididymis include adenomatoid tumors and leiomyomas. The adenomatoid tumor is a lesion of Mullerian duct origin and occurs in both sexes with a peak

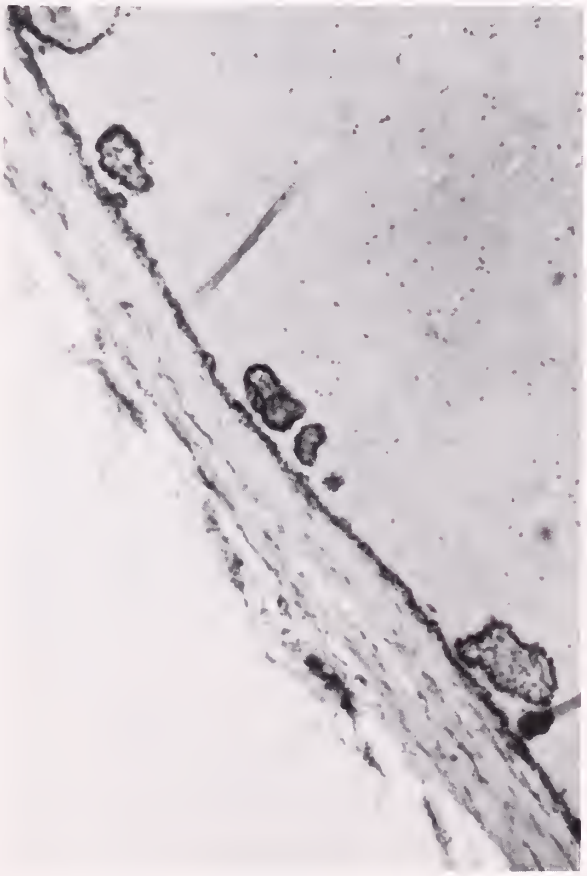

**Figure 1. Low magnification showing wall of the cyst, lining epithelium, papillary formations and hemorrhagic content.**

incidence of 40 years of age. It is usually a small lesion (one centimeter in size) located in the globus minor, more often on the left side and not necessarily connected to the duct system of the epididymis. Approximately 20 per cent will have associated hydroceles.[9,5]

Leiomyomas of the epididymis, like adenomatoid tumors, present as a painless mass. Fifty per cent of the cases are accompanied by a hydrocele and 15 per cent are bilateral. The peak incidence is in the fifth decade, and they are seen much less frequently than adenomatoid tumors (1:10).[9]

Papillary cystadenoma of the epididymis are quite rare with approximately 40 cases reported to date. These tumors are usually unilateral and sometimes multiple in nature. When the tumor occurs bilaterally it is frequently associated with Von Hippel-lindau's disease.[5,9,10]

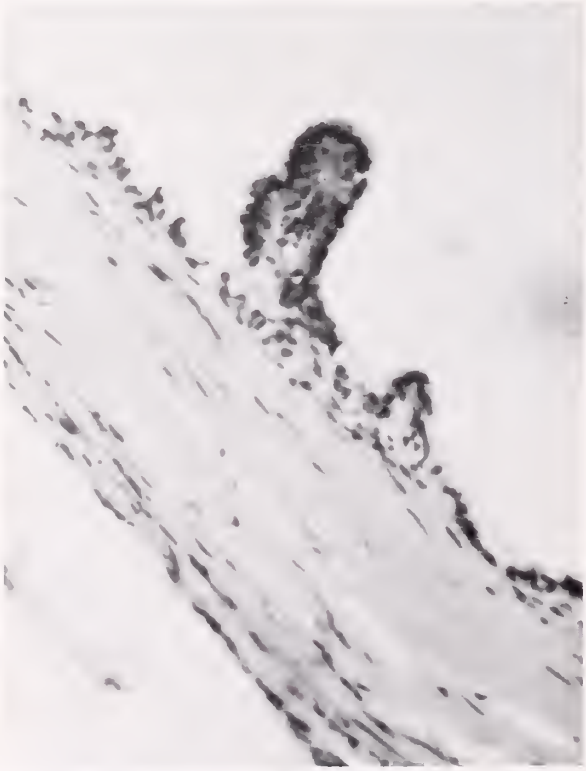

**Figure 2. Closer view of papillary formations.**

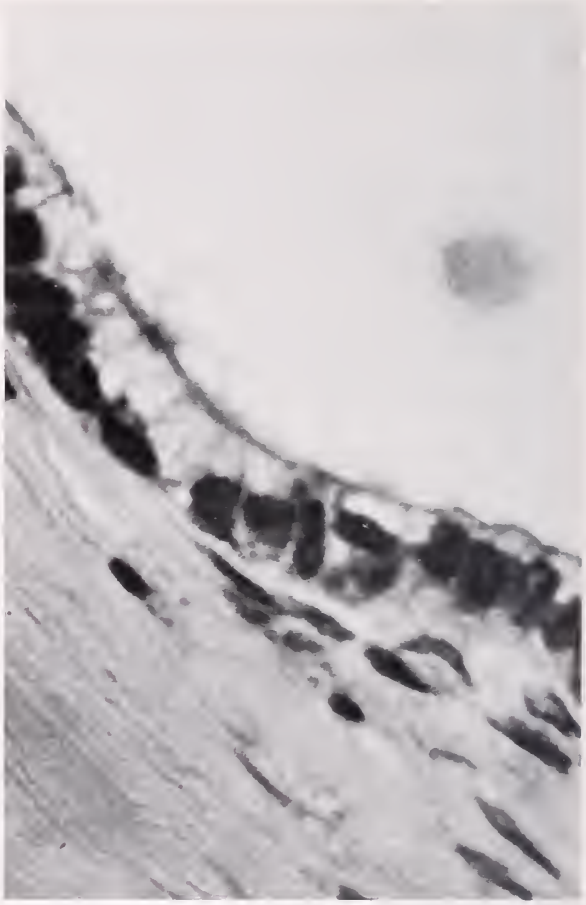

**Figure 3. High magnification showing the single layer of lining of low columnar-to-cuboidal cells.**

### References


1. Broth G, Bullock WK, Morrow J: Epididymal tumors. 1. A report of 15 new cases including review of literature. 2. Histochemical study of the so-called adenomatoid tumor. *J Urol* 100:530-536, 1968.

2. Brown NJ: Miscellaneous tumors of mainly epithelial type. *Brit J Urol* 36:70-77, 1964.

3. Chan YH, Schinella RA, Draper JW: Papillary clear cell cystadenoma of the epididymis. *J Urol* 100: 661-665, 1968.

4. Collins DH, Pugh RC: Classification and frequency of testicular tumors. *Brit J Urol Suppl* 36:1-11, 1964.

5. Elsasser E, Carl P: Primar Tumoren des Nebenhodens. *Munch med Wschr* 20:978-981, 1972.

6. Fisher ER, Klieger H: Epididymal carcinoma (malignant adenomatoid tumor, mesonephric mesodermal carcinoma of epididymis). *J Urol* 95:568-572, 1966.

7. Golden A, Ash JE: Adenomatoid tumors of the genital tract. *Am J Path* 21:63-79, 1945.

8. Gowing NFC, Morgan AD: Paratesticular tumors of connective tissue and muscle. In: *The Pathology of Testicular Tumors.* Edinburgh and London, Livingstone, 1964. *Brit J Urol Suppl* 36:78-84, 1964.

9. Becca DJ, Kane R, Olson K: Clinical management of non-testicular intra-scrotal tumors. *J Urol* 116:476-479, 1976.

10. Grant and Hoffman: Bilateral papillary adenomas of the epididymis. *Arch Path* 76:620-625, 1963.

# Hemostasis In Suprapubic Prostatectomy Utilizing Gelfoam Cone

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*The history of suprapubic prostatectomy and an operative technique utilizing Gelfoam Prostatectomy Cone* for hemostasis are described. The results of 28 patients undergoing open prostatectomy at the Clarksburg, West Virginia, Veterans Administration Medical Center are presented. Intraoperative blood loss was significantly diminished when the Gelfoam cone was used. There was no incidence of excessive scar tissue or calculus formation. Suprapubic prostatectomy using a Gelfoam cone is a safe and effective method of enucleating the benign, obstructing prostatic adenoma.*

SUPRAPUBIC (transvesical) prostatectomy represents one of the oldest methods of open prostatectomy. The first such operation was performed in this country by Belfield in 1886.[1] Gradual improvement in operative exposure and visualization as well as better control of hemorrhage helped this procedure to evolve from a primitive, blind operation to its current highly-developed state.[2]

Suprapubic prostatectomy is well suited to the removal of large, benign, obstructing adenomas (greater than 40 gm.) and to the concomitant removal of bladder calculi or diverticuli. The procedure is contraindicated in patients with known adenocarcinoma, as capsular invasion prevents complete enucleation of the gland. The presence of a bladder neck contracture or a small fibrous gland also is a contraindication to this procedure. Excessive hemorrhage is often encountered in attempting to remove a small benign gland (20 gm) by this method.

Postoperative hemorrhage greatly contributed to the early morbidity and mortality of this procedure. In 1892, E. L. Keyes, Sr., described the methods of hemostasis that were then in current use.[3] Direct pressure, cautery, hemostatic sutures, and gauze packing of the prostatic fossa were all commonly employed. Specially-designed tampons fashioned from multiple layers of gauze were packed within the prostatic fossa and were brought through the suprapubic wound, the urethra, or through a perineal urethrostomy.

Irrigation of the bladder and prostatic fossa, including use of hot water, boracic, or silver ni-

*Gelfoam Prostatectomy Cone is a product of the Upjohn Company.

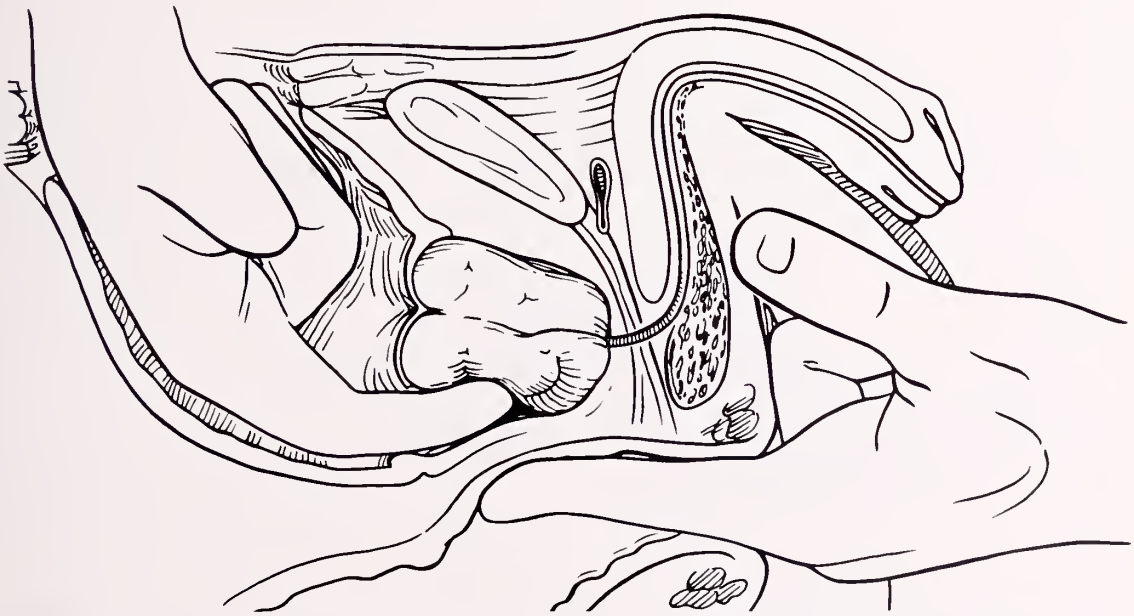

**Figure 1. Anterior pressure of assistant's gloved finger in rectum facilitates enucleation of obstructing adenoma.**

trate solution, was advocated toward the turn of the century.[2] Hemostatic bags with inflatable ballons to tamponade the prostatic fossa were designed by Pilcher and by Hagner.[4,5] These were later replaced by the double lumen Foley catheter with its self-retaining, inflatable balloon. The latter drainage tube is routinely used today in all prostatic surgery.

In 1913, Cabot urged the use of hemostatic bladder neck sutures to control the main source of prostatic arterial hemorrhage.[6] Various instruments and suturing techniques subsequently were devised, including the Hugh Young boomerang needle and the use of occlusive stitches about the bladder neck. [7,8] The latter technique was repopularized by Malament, who recently advocated the use of a removable nylon purse-string bladder neck suture.[9]

The use of a fibrin paper to control inaccessible venous bleeding was described by Samuel Harvey in 1918. [10] This fibrin paper is derived from human plasma protein coagulation factors which are readily available due to large-scale plasma fractionation. [11] It has a foamy matrix which serves both as an absorbable tampon and as a hemostatic agent. Although fibrin "foam" had great success in prostatic surgery during the mid 1940s, [12,13] nothing has been published about its use in the recent urologic literature. Because of the lack of recent interest in this technique, the procedure of suprapubic prostatectomy utilizing a Gelfoam cone will be described, and review of perioperative morbidity related to hemorrhage will be discussed.

**Operative Description**

The operative procedure is similar to that as described by Thompson-Walker in the British Journal of Surgery in 1920.[14] Through a midline suprapubic incision, the rectus fascia is longitudinally incised, and the rectus muscle bundles are retracted laterally. The prevesical space is developed with blunt dissection, sweeping the peritoneum superiorly. The bladder which has previously been distended with 250 cc. of sterile saline is grasped between two Allis clamps. A stab wound incision is made in the dome and stay sutures of 0 chromic catgut are placed on either side of the vesicotomy incision.

Next, the bladder is digitally explored with removal of all vesical calculi. The ureteral orifices are identified, and care is taken to avoid their subsequent injury during enucleation. The right index finger is inserted into the bladder neck. With anterior pressure exerted against the symphysis pubis, the prostatic adenoma is fractured between the 11 and 1 o'clock positions to the level of the prostatic apex. A cleavage plane is developed between the adenoma and the surgical capsule. An assistant's gloved finger in the rectum is routinely used for counter pressure (Figure 1). This greatly facilitates enucleation of the adenoma. The lobes are often removed separately if the gland is large or if there is adherence to the posterior commissure.

Following removal of the adenoma, a Millin retractor is placed within the bladder. The prostatic fossa is packed with two sterile gauze sponges. Figure-of-eight sutures of 0 chromic

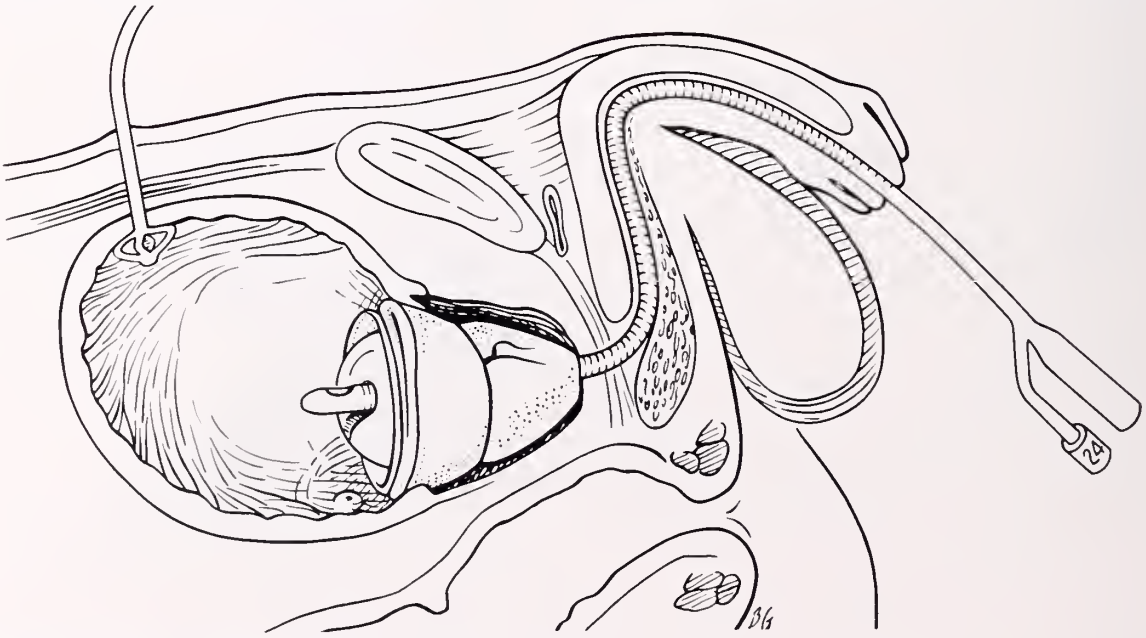


**Figure 2. Gelfoam cone is secured within prostatic fossa around a No. 24 French 2-way Foley catheter. A No. 26 Malecot suprapubic tube is in place.**

catgut are placed at 4 and 8 o'clock at the bladder neck. The prostatic packs are removed, and a No. 24 French Foley catheter is inserted per urethra into the bladder. The tip of an 18-cm.-diameter Gelfoam cone is excised. It is then fitted around the catheter as the balloon is filled with 30 cc. of sterile water. The base of the cone is secured at the midportion of the catheter balloon using a single 0 chromic catgut ligature. The apex of the cone is inserted into the bladder neck and gently guided into the prostatic fossa (Figure 2). Traction on the urethral Foley has not been found necessary to control hemostasis.

A one-inch penrose drain is placed in the space of Retzius and brought out through a separate stab wound. A No. 26 Malecot suprapubic catheter is used as an additional safety factor. The Foley catheter and suprapubic tube are connected to sterile, closed, dependent drainage systems. The bladder is closed in a water-tight fashion with running 0 chromic catgut. The wound is anatomically closed in individual layers.

Postoperatively, adequate hydration is maintained to assure good urine output. Catheter irrigation is rarely necessary, but is easily accomplished with the presence of two drainage tubes. The suprapubic tube is removed when the urine is clear, usually the second or third postoperative day. The urethral catheter is removed on the seventh postoperative day with the patient ready for discharge at 10 to 12 days after surgery.

**Discussion**

Forty-six patients underwent suprapubic prostatectomy at the Clarksburg, West Virginia, Veterans Administration Medical Center between December, 1973, and December, 1977 (Table 1). Prior to July, 1976, Gelfoam Prostatectomy Cones were not used, but all other aspects of the procedure were the same. Each patient had serial hemoglobin and hematocrit determinations during his hospitalization. Transfusion was not performed unless the inoperative blood loss was greater than 800 cc. or the postoperative hemoglobin was less than nine grams.

Of the patients undergoing "standard" prostatectomy prior to July, 1976, intraoperative blood loss averaged 550 cc. with five patients receiving a total of nine units of blood. Estimated blood loss in this group ranged from 90 cc. to 1000 cc. The duration of the procedure was also longer in these patients, averaging one hour, 36 minutes.

In contrast, the use of Gelfoam Prostatectomy Cones after July, 1976, was associated with an average intraoperative blood loss of only 180 cc. with a range of 50 cc. to 700 cc. Operative time was cut to an average of 46 minutes, and no patients required transfusion during the procedure or during the postoperative period.

The postoperative courses were remarkably similar in both prostatectomy groups (Table 2).

**TABLE 1**
**Intraoperative Use of Gelfoam Prostatectomy Cone**

| | *Total Cases* | *Average Patient Age* | *Average Size of Gland Removed* | *Average Operative Time* | *Average Intraoperative Blood Loss* | *Number of Patients Transfused* |
|---|---|---|---|---|---|---|
| "Standard" Prostatectomy (prior to July 1976) | 18 | 72.5 | 59 gm. | 1 hr. 36 min. | 550 cc. | 5/18 (total of nine units of blood) |
| Gelfoam Cone Prostatectomy (after July 1976) | 28 | 71.1 | 42 gm. | 46 min. | 180 cc. | None |

**TABLE 2**
**Postoperative Course Following Suprapubic Prostatectomy**

| | *Total Cases* | *Necessary Postoperative Hospitalization* | *Hospital Acquired UTI* | *Immediate Postop Complications* | *Delayed Postop Complication* |
|---|---|---|---|---|---|
| "Standard" Prostatectomy | 18 | 13.1 days | 5/12* (41%) | 0/18 | 0/18 |
| Gelfoam Cone Prostatectomy | 28 | 13.6 days | 6/19* (31%) | 2/18** | 0/28 |

*Sterile urine preoperatively
**One superficial wound infection, one transient paralytic ileus

The average postoperative hospital stay was approximately 13 days. There were no serious postoperative complications, e.g., myocardial infarction, pulmonary embolus, sepsis or death. Only one patient developed a superficial wound infection, and he was discharged on the 24th postoperative day. Another patient developed a transient paralytic ileus which responded promptly to nasogastric suction. All patients have been followed at least six months in clinic with no evidence of stricture, incontinence or persistent urinary tract infection to date.

With reference to urinary tract infection, all patients had a urine culture with sensitivities upon admission and during the postoperative period. Parenteral antibiotics were given prior to surgery in the presence of infection or an indwelling catheter. Antibiotics were withheld if the urine was sterile.

In the "standard" prostatectomy group, postoperative catheter irrigation was frequent and led to hospital-acquired urinary tract infections in 42 per cent of patients. In contrast, a break in the closed drainage system led to acquired infection in 31 per cent of the Gelfoam prostatectomy group. It is apparent that postoperative hemorrhage and frequent catheter drainage may have directly influenced the development of urinary tract infection.

Multiple problems often occur because of intraoperative and postoperative hemorrhage. Anemia may lead to myocardial insufficiency and shock with diminished tissue oxygenation, delayed wound healing and possible wound infection. Multiple transfusions subject the patient to the risk of hepatitis. Problems inherent to postoperative hematuria are repeated catheter irrigations with increased risk of infection, as noted above. Furthermore, prolonged indwelling catheterization may lead to epididymitis, orchitis, bacteremia, and urethral stricture formation. It is therefore imperative to take all intraoperative precautions to achieve maximum hemostasis.

In summary, the technique of suprapubic prostatectomy as well as the historical progress of hemostatic control are described. The use of a Gelfoam Prostatectomy Cone greatly diminishes intraoperative and postoperative blood loss. This eliminates the need for transfusion and also diminishes the incidence of related morbidity. The routine use of Gelfoam cone is advocated in all suprapubic (transvesical) prostatectomies.

**References**


1. Belfield WT: Digital exploration of the bladder with report of ten cases, including two prostatectomies. *JAMA* 7:253, 1886.

2. Murphy LJT: *The History of Urology*, Springfield, Charles C Thomas, 1972.

3. Keyes EL Sr: The control of haemorrhage after prostatectomy. *Ann Surg* 16:454, 1892.

4. Pilcher PM: Technique of transvesical prostatectomy. *Surg Gynecol Obstet* 24:162, 1917.

5. Hagner FR: A new method of controlling haemorrhage following suprapubic prostatectomy. *Surg Gynecol Obstet* 19:667, 1914.

6. Cabot H: Factors influencing the mortality of suprapubic prostatectomy. *Surg Gynecol Obstet* 17:689, 1913.

7. Young HH: Conservative perineal prostatectomy: Presentation of new instruments and technique. *JAMA* 41:999, 1903.

8. Harris SH: Suprapubic prostatectomy with closure. *Surg Gynecol Obstet* 50:251, 1930.

9. Malament M: Maximal hemostasis in suprapubic prostatectomy. *Surg Gynecol Obstet* 120:1307, 1965.

10. Harvey S: Fibrin paper as an haemostatic agent. *Ann Surg* 68:66, 1918.

11. Bering, EA: Chemical, clinical, and immunological studies on the products of human plasma fractionation. XX. The development of fibrin foam as a hemostatic agent and for use in conjunction with human thrombin. *J Clin Invest* 23:586, 1944.

12. Quinby, WC, Landsteiner, EK: Fibrin foam as a hemostatic agent in suprapubic prostatectomy. *N Engl J Med* 233:267, 1945.

13. MacDonald SA, Powell RE: Gelfoam hemostasis in prostatic surgery. *J Urol* 57:812, 1947.

14. Thompson-Walker JW: Haemorrhage and postoperative obstruction in suprapubic prostatectomy: An open operation for their prevention. *Brit J Surg* 7:525, 1919-20.

# Gastric Distress Evoked By Anti-Inflammatory Drugs

JOHN C. KRANTZ, JR., Ph.D.
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*It is strikingly coincidental that the generally-used, anti-inflammatory analgesic drugs evoke a high incidence of gastrointestional distress and bleeding. Recently, several new drugs containing a variety of chemical rings and side chains have been introduced, but it is too early to tell whether these agents will elicit gastric distress. For the present, buffered aspirin remains the drug of choice.*

It is strikingly coincidental that the generally-used, anti-inflammatory, analgesic drugs evoke a high incidence of gastrointestinal distress and bleeding. This cannot be due to higher dosage levels than drugs used for other purposes, since indomethacin with a comparatively low dosage level evokes the same untoward side effects. It cannot be caused by a longer period of medication, since the treatment of such conditions as hypertension and coronary insufficiency is continued for as long or even longer time periods. The four principal drugs used for this purpose are aspirin, indomethacin, corticosteroids and phenylbutazone. For a period of time, the anti-malarial drugs chloroquine and hydroxychloroquine were used in the treatment of rheumatoid arthritis, and one of the frequent side effects was gastrointestinal distress.

Recently, several new drugs containing a variety of chemical rings and side chains have been introduced and are being used in the neuromuscular pain of arthritis. Among these are Naproxen d-2-[6'-methoxy-2'-napthyl] propionic acid and Mortrin (±)-2-(p-isobutylphenyl) propionic acid, and Tolectin 1-methyl-5-p-toluoylpyrrole-2-acetic acid. It is too early to tell whether these agents will elicit gastric distress in a segment of the population until they have been used extensively for long periods of time.

### Buffering Aspirin

Aspirin has, of course, been known longer than any other of the previously mentioned drugs. Its effect upon the gastrointestinal tract was investigated by W. D. Paul.[1] He observed that buffering aspirin diminished its irritating action on the gastrointestinal tract. H. E. Tebrock[2] used aspirin in 1,000 cases of headache and muscular pain. Seven per cent of the individuals complained of gastrointestinal distress. In a similar study using buffered aspirin, two per cent of the individuals experienced gastrointestinal symptoms. More recently, M. Levy[3] reported that only 0.015 per cent of those who are heavy aspirin users show gastric distress. The American public ingests approximately 20 tons of aspirin daily.

It is interesting to note that gastric hydrochloric acid and the drug evoke the distress often accompanied with gastric microbleeding. This is in accordance with the concept of H. W. Davenport[4] that certain agents such as aspirin, alcohol, bile salts and other potentially irritating agents in the presence of acid break the mucosal-blood barrier and cause microbleeding. Buffering to produce the sodium salt of aspirin in solution and neutralizing the gastric contents to pH 6 protects the mucosal barrier and maintains the potential difference with respect to H+ at normalcy.

### Cost Comparison

In the discussion of "Gastrointestinal Blood Loss" caused by anti-inflammatory agents, Hanauer[5] compares the cost of buffered aspirin with Fenoprofen, a complex organic compound with anti-inflammatory activity. A daily dose of this agent, 2.4 grams, costs about one dollar and the buffered aspirin only 10 cents. Besides, there is no established advantage in the use of the more complex chemical compound.

When one sees the structure of new therapeutic agents with various rings and side chains useful in the treatment of arthritis, the words of the late English biochemist, Sir Frederick G. Hopkins, come to one's mind applicable to the treatment of arthritis. "In a country rich in gold, observant wayfarers may find nuggets on their path, but only systematic mining may provide the currency of nations." Until the specific chemical entity is synthesized, aspirin will remain the drug of choice.

### References

1. Paul WD, Dryer RL, Routh JI: *J Am Pharm A* 39:21, 1950.
2. Tebrock HE: *Indust Med & Surg* 20:480, 1951.
3. Levy, M: *Am J Dig Dis* 17:1055, 1972.
4. Hanauer LB: *JAMA* 238:937, 1977.

*A message from . . .*

*The President*

## THE HARD SELL

I don't regard myself as particularly irritable. And I've never been inclined to brood, at least excessively. Separate bits of irritants, however, have a way of accumulating, perhaps like holes in your socks. One or two in a drawer full is tolerable but when every second sock is so afflicted it does something to you. It can ruin your whole day.

Have you ever noticed the number of public service announcements on TV and radio or the corresponding PR schlock obsequiously or, perhaps, just mindlessly printed in newspapers? The numbers seem to be increasing all the time. They're not all that bad, either.

I've been downright tempted a number of times recently to go down to the Social Security office to check on the possibility of getting a little disability income. The desirability of being found eligible for food stamps has been going up in direct proportion to the size of the supermarket bill even without media encouragement to apply. Recent cold weather seems to have brought on a blizzard of invitations to come down and get a little help with my fuel bill.

The Department of Agriculture and Labor Department are always asking me to write for fascinating-sounding information or services. Some of the more sophisticated bureaus following good business practice seem to be developing toll-free numbers.

Then, too, there's the local Mental Health Center. The possibilities presented here seem almost endless. If I drink a little bit too much, fight with the wife, have trouble with the neighbors, happen to get raped, can't make it to work often enough, don't know what to do with the kids or just generally need advice or someone to talk to, they've got just the right program to make me feel all better. If I weren't already in the business and able to recognize the hyperbole, I'd have been down there long ago.

The question that keeps popping up in my mind is why must they merchandise these programs so heavily if there is such a crying need for them that they were found necessary in the first place? I can understand Chrysler's problems. Do these programs have the same trouble as Chrysler? Might we have government buildings full of expectant but yawning helpers without the hard sell?

I have examined a budget or two submitted by agencies, some quite small, within HEW (now the Department of Health and Human Services) and have been surprised at the number of PR positions slotted and funded. I am sure there are very talented people who fill these positions—which observation, in itself, might place them a cut above the general run of government employees. The quantity of their work or output per man hour, moreover, must certainly be exceptional.

Nonetheless, I think they all ought to be fired. The Federal Government already has a monopoly on welfare generosity. With whom does it compete? Drummers and hucksters clearly are not needed. They add nothing to whatever benefits any welfare program might offer the bona fide needy. Without them we might be able to assess the real need for the programs, rather than the need of those operating the programs for a secure job.

Stephen D. Ward, M.D.

Stephen D. Ward, M. D., *President*

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

**EDUCATION**

Medical education again stirred up a wide range of discussion, and controversy, during the Interim Meeting of the American Medical Association's House of Delegates in December. At the center of most of the debate was a detailed AMA Council on Medical Education report entitled "Future Directions for Medical Education."

That document offered proposals and recommendations ranging in subject area from admission to medical school and residency training to licensure and evaluation of physicians. More specifically, it found a need for the restructuring of the third and fourth years of medical school; creation of a "comprehensive residency" for all first-year residents, and establishment of a committee of "public and professional statesmen" to make policy recommendations to the Council.

In an ultimate decision to move cautiously, the House directed that the report be filed, with its concepts and principles to become "an agenda of issues for discussion, followed by the development and review of more specific recommendations."

It wasn't hard to understand why the report quickly became controversial, both in reference committee and on the floor of the AMA House. Medical school representatives criticized it for failing to take into account innovations tried by many of the nation's new medical schools. Another medical school spokesman found "unnecessarily inflammatory statements" in the report, but said he agreed with the overall theme.

Actually, no one felt the report would be completely acceptable. A Council on Medical Education spokesman said it was a "good basis on which to begin a real examination of the issues" it raised. And that perhaps was the most significant contribution to the debate.

The AMA has been formally involved since the beginning of this century in improving standards for medical education. To a varying degree, so have state and local medical associations and societies. The West Virginia State Medical Association, among other things, serves as an accrediting agency for the AMA for continuing medical education programs offered by community hospitals, and some other organizations.

A special committee report to the AMA House in 1904 said that "efforts to make uniform and elevate the standard of medical education can be made most effective through the agency of the organized medical profession. . ." That purpose has not changed.

On recommendation of its Council on Medical Education, the AMA has established educational standards for medical schools; for graduate medical education, and for continuing medical education (CME), an on-going course of instruction which physicians maintain throughout their years of practice.

Against that kind of background, the Council's new report well might be considered as a true example of the AMA really at work in one key direction for which it was established. Of course the complex new report is not perfect. It probably never will be. But it does represent, as the House very properly decided, an "agenda of issues." And certainly future educational efforts of the AMA, across the board, should be much stronger and more productive because of the many hours of labor that it represents.

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**OCCURRENCE AND CLAIMS-MADE**

As noted in the State Office's year-end bulletin to Association members, West Virginia's Insurance Commissioner has approved a claims-made filing by St. Paul Fire and Marine Insurance Company to write professional liability (malpractice) insurance for the State's physicians.

Some questions have been directed to the Association Headquarters relative to occurrence and claims-made coverage. An effort was made in the year-end material to spell out the difference

between the two kinds of policies. Perhaps, however, some additional discussion might be helpful.

Comparing occurrence and claims-made policies generally is like the apple/orange dilemma and is difficult, but it is essential that it be done if a wise choice is to be made. As in most purchases, price alone can't be the sole deciding issue. There are many pros and cons that need to be understood and considered. Claims-made insurance can be a viable choice for some if considered in depth.

It appears some perspective can be added to the discussion by noting that insurance companies have wanted this kind of policy. It didn't come about because of consumer pressure. The companies said, in effect, "we will only write this kind of policy, or we will not write." St. Paul has said this in West Virginia in 1975. The primary reason for this position generally has been that a more accurate rate could be actuarially computed, but coverage had to be restricted to achieve this benefit.

We won't dwell on the fundamental differences of the two policies. As noted above, we tried to do that earlier. We feel they're understood, for the most part. Perhaps, however, we should point out some considerations that are important.

First, the concept of purchasing at some point in time what is commonly called "tail" coverage might cause these concerns: (1) there is a loss of flexibility because, if it is decided to *change* the program for *any* reason, the tail must be purchased; (2) if the company offering the coverage decides to no longer provide this line of insurance, the insured has to buy the tail at a time the company decides upon, not the insured; and (3) the exact cost of the tail coverage is estimated and can't be budgeted for accurately. A crisis in the line or a pattern of bad experience episodes will impact directly on cost of the tail that must be bought. It can be looked upon as a hidden cost item, plain and simple.

There perhaps are these other concerns: (1) the plan has no dividend feature; (2) limits of liability are different than the present policies; and (3) some members of the profession might cancel their policies and leave the state or country without purchasing the tail. Claims against them will be almost impossible to resolve and the public might hold this against the profession or the sponsoring arm of the profession.

There are some good points to be considered, too: (1) the initial cost is low and the new physician who has all the other expenses of getting started can better pay the initial premium; (2) the concept of pay-as-you-go has some appeal, especially if current costs aren't deferred in some manner, because of competition or similar business consideration only to be picked up later by inflated dollars in the tail; (3) the money needed for the tail can be set aside and invested in any manner decided upon; (4) favorable loss experience might be reflected in the rates sooner, as opposed to a dividend plan; and (5) there probably wouldn't be the problem of settling claims at today's values with limits of liability applicable *long ago*, but now eroded by inflation.

No discussion of the policies would be complete until the integrity of the company was considered. The reputation and financial staying-power obviously must be considered. Coverage of any kind isn't much good if the carrier is "broke" or no longer in business. The company's general philosophy of how claims are to be handled is important. A company's commitment to loss control activities and the general effectiveness of the program are important. And ability of the company to write other forms of needed insurance for insureds has to be addressed.

Other items probably also need to be considered in this general question. It's a complicated issue, and some individuals might not be inclined to delve deeply enough into it before making a decision.

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**A CHECKLIST FOR COST CONTROL**

Individual physicians can contribute significantly to efforts to hold down health care costs. In fact, doctors both collectively and individually have a new responsibility in this direction after congressional rejection of the Carter Administration's cost containment legislation, and concurrent recognition of the Voluntary Effort (VE) program.

To help in physicians' efforts, we recommend highly an American Medical Association pamphlet entitled "Physician's Cost Containment Checklist." It literally covers the waterfront in key areas such as doctor-patient relationships; doctors' work with and in hospitals, and the business aspects of medical practice.

The checklist items, in the form of questions, are comprehensive and squarely in line with an official AMA dedication to initiatives designed to contain health care costs while protecting patients' rights to uncompromised standards of care.

The State Medical Association's Headquarters Office in Charleston has a limited number of these pamphlets.

# Our Readers Speak

## Can't Reform Tort System

The December, 1979, issue of *The West Virginia Medical Journal* contained two articles about which I have some knowledge.

The first article was an editorial by Dr. Stephen Ward regarding professional liability. No doubt Doctor Ward reflected the general concern that physicians have and will continue to have in the future regarding the cost of medical malpractice insurance and the incidence of litigation. However, like most physicians, this editorial reflected a lack of understanding of the law and, specifically, the civil law system in West Virginia and the United States.

We as physicians must not rely upon the "tort system" being reformed. What physicians need to do is to be able to use that system to their best advantage. Physicians cannot choose the weapons that they must duel with, but this lack of choice does not mean that the doctors should not become proficient in the use of these weapons.

It has always been my opinion, and I have seen nothing during my practice of law to change this opinion, that doctors, like other individuals, are pawns or objects that attorneys use to necessarily correct wrongs, and, as a byproduct, to make a living. You will never be able to remove the physician, nor any other individual, from the potential of being a "victim" of our tort system, if what we mean by "victim" is being a part of a civil litigation. What can be prevented is the failure of the physician to be vindicated by civil litigation. No one likes to be sued, but the important thing is to ultimately win that lawsuit.

This idea of winning must be the object the physician strives for. If all our efforts are to prevent us from being sued, I can tell you now that such reform will never happen under our present governmental structure as we know it.

Briefly, now, since I have taken so much time, I would like to state that the risk management article submitted by the agent of Aetna Life and Casualty of Hartford, Connecticut, was interesting. What this article failed to state, however, is that these proposals for risk management have been talked about within the State Medical Association for some years. Aetna always has had the ability to institute the type of review that is outlined in that article. The main point, however, is that the physicians who are the insured must actually have the control over the review of other physicians as well as the ability to set premium rates. I doubt very much Aetna will ever allow the physicians that they insure to make probably the most important advance for the protection of physicians: the choice and review of defense counsel.

Richard D. Lindsay, M. D., J. D.
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*Editor's Note*:

Doctor Lindsay is mistaken in assuming that the editorial he cites was concerned only with malpractice insurance rates. Perhaps he is correct in assuming we do not understand civil law. We do understand, however, that the law is not immutable. Parts of the "tort system," as we understand it, that need change are the unreasonable time period covered under the statute of limitations, the imposition of punitive damages in awards and the failure of that system to make adequate differentiation between bad results and actual malpractice, to name a few.

Our greatest concern, however, is the continuing availability of adequate, skilled and affordable care to patients. It is our feeling that physicians are sometimes intimidated by legal threats into rejecting difficult or complicated cases, and avoiding risky diagnostic or therapeutic procedures. We are inclined to blame such unfortunate occurrences on certain predatory members of the legal profession encouraging and promoting law suits rather than on an avaricious patient public or a cowardly medical profession.

Rather than learning to manipulate the legal system to their own advantage, physicians want simply to be left alone to practice medicine without the unwarranted and unreasonable possibility that now exists of being hauled into court to be badgered and harassed by attorneys more interested in procedure and money than in common sense and justice.

It is probably understandable that a lawyer would give primacy to civil rights over any potential medical care benefits. It should be equally understandable, however, that physicians must have exactly the opposite priorities.

Lawyer-Doctor Lindsay is floating somewhere between two worlds.

## Questions Use of Articles

*The West Virginia Medical Journal*, Vol. 75, No. 11, November, 1979, arrived today. In reading through it, I again see an article by Dr. Richard D. Lindsay.

I question the wisdom of allowing this man to continue to have medico-legal articles printed in *The Journal*. This man is now suing physicians . . .

I do not question his right to sue physicians. However, I do question the wisdom of allowing him to contribute medico-legal articles to *The West Virginia Medical Journal* which would then allow him to quote himself as a frequent contributor to our . . . *Journal*.

I feel that defendants' rights in malpractice trials have been trampled too severely, as reflected in our continuing increases in malpractice insurance rates. I believe that this is one area where *The Journal* could be helpful to physicians.

I did not think the specific article was interesting, informative, or educational.

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Morgantown 26505

## Sarcoid Heart Not Rare

With reference to the article by Cooksey and Crisalli in the December issue of *The Journal*, page 355, I would like to make some comments. They suggest that 20 per cent of patients with sarcoidosis at postmortem can be demonstrated to have cardiac involvement. Surely this is an underestimate, for unless very large numbers of sections are taken, microscopic granulomas can very easily be missed.

The . . . authors state that only 10 cases of documented clinical involvement of the heart had been reported. On the contrary, Fleming reported[1] 128 cases alone from United Kingdom at the VIIIth International Congress on Sarcoidosis in 1979, and it is interesting to note that only 10 of these 128 patients were black. It is not a rare disorder, though it was thought to be so until recently.[2]

Cardiac assessment by radioisotope studies and echocardiography is rather helpful in evaluating and following such patients, which the authors neglected to mention.

The importance of sarcoid heart is being increasingly recognized in connection with flying personnel.[3] Therefore, I suggest that sarcoid heart disease should not be overlooked in any case of sudden death or unusual heart disease.

Saeed Ahmad, M. D.
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1. Fleming HA: Sarcoid heart disease, proceedings of VIIIth International Congress on Sarcoidosis, 1979.
2. Silverman KJ, Hutchins GM, Bulkley BH: Cardiac sarcoid: *Circulation* 58:1204, 1978.
3. Fleming HA: Too few necropsies—sarcoid heart disease. *Br Med J* 2:1146, 1979.

# GENERAL NEWS

## JAMA Editor To Address Annual Meeting

William R. Barclay, M. D., Editor of The Journal of the American Medical Association (JAMA), will deliver the keynote Thomas L. Harris Address for the 113th Annual Meeting of the West Virginia State Medical Association.

Doctor Barclay will speak during 9 A. M. opening exercises on Thursday, August 21, it was announced by Dr. M. D. Reiter of Wheeling, Chairman of the Program Committee.

The convention will be held August 20-23 at the Greenbrier in White Sulphur Springs.

The annual Thomas L. Harris Address was established with a bequest in the will of the late Dr. Thomas L. Harris, Parkersburg surgeon who served as President of the Association in 1945.

Doctor Barclay was Director of Scientific Activities and Assistant Executive Vice President for the AMA from 1970 until 1976, when he was named JAMA Editor.

A Fellow of the American College of Physicians and American College of Chest Physicians, Doctor Barclay was Professor of Medicine at the University of Chicago from 1964 to 1970.

Convention activities will get under way with a 2 P. M. meeting of the Association's Executive Committee on Tuesday, August 19; the usual pre-convention meeting of the Council at 9:30 A. M. on Wednesday, and the opening session of the House of Delegates at 3 P. M. on Wednesday.

#### Past President of Thoracic Society

Doctor Barclay also is a member of the Editorial Board of the Journal of Infectious Diseases, and is a Consultant for the Staff of the Chicago State Tuberculosis Sanitarium, the Pan-American Health Organization, and the World Health Organization.

He was President of the American Thoracic Society in 1959-60.

A native of Golden, British Columbia, Canada, Doctor Barclay was graduated from the University of British Columbia, and received his M. D. degree in 1946 from the University of Alberta in Edmonton, Alberta, Canada.

Robert B. Hunter, M. D., of Sedro Woolley, Washington, who will be installed as the President of the American Medical Association in July, has been invited to address the first session of the House of Delegates on Wednesday afternoon, the Program Committee also announced.

The first general session will be held immediately following the 9 A. M. opening exercises on Thursday, with general sessions also scheduled for Friday and Saturday mornings.

#### Subjects of Papers

The Thursday and Friday sessions will include papers on the subjects of photochemotherapy, dermatology, pharmacology, psychiatry, and children's learning disorders.

The Saturday morning session will feature talks on AMA services and the activities of the AMA's Washington office.

The general convention format once again will provide opportunities for breakfast, luncheon

**William R. Barclay, M. D.**

and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 22).

Plans also call for the usual President's Reception on Wednesday evening, August 20, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P. M. on Saturday. At that House session, Dr. L. Walter Fix of Martinsburg will be inaugurated as President to succeed Dr. Stephen D. Ward of Wheeling.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. D. Sheffer Clark of Huntington in charge as the Auxiliary's President, again will run concurrently with the Association's convention.

**Reservations Encouraged**

More specific information relative to other general session topics and speakers will be provided in upcoming issues of *The Journal.*

Reservation forms normally provided by the Greenbrier at the beginning of the year were delayed, but were to be mailed to all Association members as soon as available. Those planning to attend the Annual Meeting are encouraged to give them their earliest possible attention.

Serving on the Program Committee with Doctor Reiter are Doctor Fix and Drs. David K. Heydinger of Marshall University's School of Medicine in Huntington; Joseph B. Reed, Buckhannon; Stanley Roy Shane of the West Virginia School of Medicine faculty in Morgantown, and John F. I. Zeedick of South Charleston.

**Dr. L. Walter Fix (left) of Martinsburg, President Elect of the West Virginia State Medical Association; Dr. Jack Leckie of Huntington, an alternate delegate to the American Medical Association House of Delegates; and Dr. Stephen D. Ward of Wheeling, the Association's President, take part in a West Virginia caucus during the December Interim Meeting of the AMA House in Honolulu.**

## Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

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|---|---|---|
| Mar. 21 | Charleston | 7th Annual Newborn Day |
| Mar. 28-29 | Morgantown | Neurosciences Teaching Day |
| April 18 | Morgantown | 6th Annual ENT Teaching Day |
| April 19 | Wheeling | Annual Postgraduate Day in Surgery |
| April 26 | Morgantown | W. Va. Assn. of Pathologists, Scientific Session |

**Visiting Professors**

(Morgantown)

April 3-4 *Dept. of Obstetrics and Gynecology*: "Perinatal Outcome in Pregnant Epileptics" and "Hyperthyroidism in Pregnancy," Luis B. Curet, M. D., University of Wisconsin, Madison.

April 18 *Dept. of Radiology*: Melvin Clouse, M. D., Chairman, Department of Radiology, New England Deaconess Hospital, Boston.

*Dept. of Anesthesia*: One Thursday each month, 4 p.m.

*Dept. of Medicine*: Variable—incorporated in Grand Rounds

*Dept. of Family Practice*:—Variable incorporated in Grand Rounds

## AMA House Actions Cover Major Health Issues

Here is a summary of major action resulting from the Interim Meeting of the American Medical Association's House of Delegates in Honolulu in early December, 1979. More detail with regard to any of these issues may be obtained from the State Office of the West Virginia State Medical Association.

(In addition to the many items of business requiring consideration, Dr. Hoyt D. Gardner of Louisville, President of the AMA, called for a new determination to restore public confidence in all professions. Doctor Gardner noted that each physician must continue to earn the public's trust with each patient encounter. He also called for more medical family involvement in the family life and health of America, and for voluntary local initiatives by organized medicine for the public good.)

Major actions of the House at the meeting included a reaffirmation of the Association's policy on National Health Insurance; an initial review of a comprehensive report from the Council on Medical Education; a new position calling for revision of the Delaney Clause of the FDA Law; receipt of several reports pointing out the necessity for increased membership recruitment activities; and a statement opposing the use of the phrase "reasonable charge" by Medicare when use of the phrase misleads patients.

*National Health Insurance*: Usually in the forefront of controversial issues before the House, National Health Insurance generated little debate at this meeting. The House clearly was satisfied with the Association's NHI policy and swiftly reaffirmed the 1978 principles on National Health Insurance while at the same time commending the Board of Trustees.

The House adopted a Board report that called for a continuation of current initiatives of the AMA so as to ensure that the NHI principles can be forcefully articulated and fully considered in any dialogue that takes place in Congress.

Briefly stated, the AMA's policy is to maintain the high quality of medical care within the framework of private health insurance.

**The best way to prepare for a day-long session of the American Medical Association's House of Delegates is to demolish a good breakfast at a 7 A. M. caucus and then review reference committee reports on the upcoming agenda. From left to right are the West Virginia State Medical Association's two delegates to the AMA House, Drs. Richard E. Flood of Weirton and Frank J. Holroyd of Princeton, prior to floor consideration of resolutions, reports and other matters at the House's Interim Meeting in Honolulu in December. At the far right, Dr. Harry S. Weeks, Jr., of Wheeling, one of West Virginia's two alternate delegates, joins in the discussion while Dr. W. Gene Klingberg, second from right, studies the material at hand. Doctor Klingberg, Chairman of Pediatrics at the West Virginia University Medical Center, is a WVU representative to the AMA's Section on Medical Schools.**

### Medical Education

*Medical Education*: The House received a 74-page background report entitled "Future Directions for Medical Education" which proposed sweeping changes in medical education. The delegates *filed* this report and directed that its suggestions become an "agenda of issues for discussion, followed by the development and review of more specific recommendations."

This comprehensive report addresses issues ranging from admission to medical school and residency training to licensure and evaluation of physicians. It states a need for the restructuring of the third and fourth years of medical school, creation of a "comprehensive residency" for all first-year residents, and establishment of a committee of "public and professional statesmen" to make policy recommendations to the Council on Medical Education.

Limited quantities of this report are available from the AMA Headquarters in Chicago.

*Delaney Clause Revision*: The House adopted an important report from the AMA Council on Scientific Affairs calling for a revision in the Delaney Clause so that: (1) risk/benefit assessments are made a part of the decision-making process; (2) alternative risks would be weighed before requiring the banning of a substance suspected of being hazardous; and (3) decision-making on food additives should be based upon the best scientific evidence available pertaining to the usefulness, function, uniqueness, health needs, and potential risk of the substance.

### Membership

*Membership*: Few issues are more frustrating to AMA delegates and others active in the national association than the continuing problem of recruiting and retaining AMA members. House members and others are aware of the important accomplishments of the AMA in behalf of the profession. They also are aware of its shortcomings, but there was no question that the AMA is worthy of membership and active support.

The bad news was that the percentage of AMA members against the U. S. physician population continues to decline. The good news was that total dues-paying members have shown a modest increase and the medical students and resident physicians now total over 20,000 members in each category.

One report showed that 42 per cent of the state societies and 63 per cent of the county medical societies have no membership recruitment activities for new members. These disturbing facts prompted AMA's Executive Vice President, Dr. James H. Sammons, to urge the members of the House to ask their local societies to re-examine their membership activities. The reference committee that considers AMA financial affairs reported that in the absence of substantial numbers of new members, Association expenses will exceed income in 1981. The high rate of inflation means that the AMA must add several thousand members each year just to maintain the same level of activity.

The Council on Long Range Planning and Development is studying various models for restructuring the Federation in an effort to resolve the long-term membership problem. The House will be considering these proposals at future meetings. In the meantime, the House urged all Delegates to become active membership recruiters.

### Called Misleading

*Medicare "reasonable charges"*: In acting on a resolution submitted by the Oregon delegation, the House condemned the use of the phrase "reasonable charge" when use of the phrase misleads patients and the public.

The Oregon delegates were objecting to the use of the phrase in a publication called "Guide to Health Insurance for People with Medicare" published by the National Association of Insurance Commissioners and HEW. The resolution explained that there is a strong inference that a physician who does not accept assignment and does not accept Medicare's "reasonable charge" as a full payment is, therefore, making "unreasonable charges."

The AMA will investigate this publication and submit a report to the House at the next meeting.

Action on this resolution was cited as an excellent example of how practicing physicians can influence AMA policy. The House of Delegates is a democratic organization and acts on business that concerns physicians and their individual practices, AMA leaders have stressed.

The House also debated and voted on a wide variety of issues, including gun control legislation; health care for refugees; strip searching; brain death legislation; treatment of chronic mental patients, and foreign medical graduates.

## 13 Speakers, 65 Exhibits Planned By AAFP

Some 13 physicians will speak on a variety of subjects during the 28th annual Scientific Assembly of the West Virginia Chapter, American Academy of Family Physicians (AAFP).

The meeting, also featuring 65 exhibits, will be held April 18-20 in Morgantown at the Lakeview Inn and Country Club.

Dr. Thomas P. Long of Man is Chapter President.

The program is approved for 22 and one-half Prescribed hours by the AAFP, and up to 10 additional Prescribed hours are obtainable through Roche Clinical Conferences, consisting of a multimedia teaching device, to be available during the meeting.

Speakers and topics for the opening session of the scientific program Friday morning, April 18, will be "Assessment and Medical Management of Coronary Artery Disease"—Robert J. Marshall, M. D., Huntington; "Nutrition and the Physician"—Frederick J. Stare, M. D., Professor of Nutrition, Harvard University School of Public Health, Boston, and "Coronary Artery Disease—Surgical Aspects"—Herbert E. Warden, M. D., Professor and Vice Chairman of Surgery, West Virginia University School of Medicine, Morgantown.

Friday afternoon speakers and topics will be "Family Practice: Update on Specialties" — Nicholas J. Pisacano, M. D., Executive Director and Secretary, American Board of Family Practice, Lexington, Kentucky; "New Concepts in Urinary Tract Infection" — Burke A. Cunha, M. D., Chief, Infectious Disease Division, and Associate Director, Department of Medicine, Nassau Hospital, Mineola, New York; and "Psychiatry and Family Practice"—Wilbur Z. Sine, M. D., WVU Clinical Assistant Professor, Department of Behavioral Medicine and Psychiatry, Morgantown.

The Saturday morning session will begin with films from 8 to 9 o'clock. The films, a contribution of The Upjohn Company, are entitled "The Technique of Intra-articular and Peri-articular Injection" and "Lubrication in Healthy and Arthritic Joints."

Speakers for the Saturday morning session will be Lee P. Van Voris, M. D., Assistant Professor of Medicine, Marshall University School of Medicine, Huntington, whose topic will be "Bacterial Vaccines — An Update;" Robert B. Belshe, M. D., MU Associate Professor of Medicine, and Chief, Section of Infectious Diseases, "Live Viral Vaccines," and R. Danison Lambright, CPBC, Professional Management of West Virginia, Morgantown, "Professional Management."

Presenting papers Saturday afternoon will be James W. Anderson, M. D., Chief, Endocrine-Metabolic Section, and Professor of Medicine and Clinical Nutrition, Veterans Administration Hospital, Lexington, Kentucky, on "High-Fiber Diets for Diabetics;" Ronald J. Saykaly, M. D., Lexington, Kentucky, "Rheumatoid Arthritis," and Emery A. Wilson, M. D., Assistant Professor, Department of Obstetrics and Gynecology, University of Kentucky Medical Center, Lexington, "Pathological Effects of Estrogen Therapy."

Doctor Long will deliver his President's Address during the annual banquet session Saturday night, with Dr. Thomas S. Clark of Morgantown presiding.

The banquet program also will include: greetings from Roger Tusken, national AAFP Executive Director, Kansas City, Missouri; installation of officers by Dr. John S. Derryberry of Shelbyville, Tennessee, national AAFP President; presentation of the Past President's Plaque and the

Frederick J. Stare, M. D.

Lee P. Van Voris, M. D.

Robert B. Belshe, M. D.

Emery A. Wilson, M. D.

Mister Doc Award, by Dr. John L. Fullmer of Morgantown, 1980-81 Chapter President, and remarks by Doctor Fullmer.

Films on "Diabetes: Special Problems in the Older Patient" and "Prostaglandins: Tomorrow's Physiology?" will begin the Sunday program at 8 A. M.

Beginning at 9 A. M., the speakers and topics will be "Otitis Media — Serous, Mucoid and Suppurative"—Ronald L. Wilkinson, M. D., of Charleston, and WVU Clinical Assistant Professor of Otolaryngology, Morgantown; and "Chronic Airflow Obstruction"—William K. C. Morgan, M. D., Professor of Medicine, University of Western Ontario, and Director, Chest Diseases Service, University Hospital, London, Ontario, Canada.

The assembly will conclude at noon on Sunday, at which time the Board of Directors will hold a luncheon meeting. (The Board also will have a dinner meeting at 7 P. M. on Thursday, April 17.)

The House of Delegates will hold a luncheon meeting on Friday from 11:45 A. M. to 1:30 P. M.

The Roche Clinical Conference, mentioned above, consists of a new medical education device which combines synchronous slide and video presentations with sound equipment. It will be available on Friday and Saturday from 8 A. M. to 6 P. M., and on Sunday from 7 to 11 A. M. in Rooms 603-604.

A champagne brunch and musical style show for ladies will be held on Saturday from 11:30 A. M. to 2 P. M.

For registration and other information, contact West Virginia Chapter, AAFP, 4760 Fire Creek Road, Charleston 25312; or telephone (304) 776-1178.

Ronald L. Wilkinson, M. D.

William K. C. Morgan, M. D.

## Dr. Justus C. Pickett Retires, Rejoins WVU Faculty

Dr. Justus C. Pickett has retired from the Morgantown group for orthopedic surgery that he headed to rejoin the West Virginia University Medical Center faculty.

He returned to the WVU staff on January 1 as Professor Emeritus of Orthopedics, it was announced by Dr. Eric L. Radin, Professor and Chairman of Orthopedic Surgery.

Doctor Pickett will head the Medical School's orthopedic ambulatory service beginning in May, Doctor Radin said. "In this position," he noted, "he will be in charge of the examination and treatment of patients in the WVU clinic. He also will see difficult problems referred by other physicians and be available for consultation."

"As Professor Emeritus of Orthopedics," Doctor Radin continued, "Doctor Pickett will play a major role in the supervision and preoperative and postoperative care of hospital patients in the orthopedic service, and in the teaching of medical students, house staff and postgraduate fellows."

Doctor Pickett was the first Chairman of the WVU Orthopedic Surgery Division. He held that position 12 years, from the time the division was founded in 1960, until forced to retire because of age regulations.

The father of State Health Director George E. Pickett, M. D., he has practiced orthopedic surgery in Morgantown and West Virginia since 1932.

## American Pediatrics Academy To Meet In Las Vegas

"Antibiotic Usage for Specific Infections" will be the title of one of 15 one-day seminars to be held during the spring session of the American Academy of Pediatrics April 19-24.

The meeting will be held in Las Vegas at the Las Vegas Hilton.

Other seminars will include those on the subjects of pulmonology, allergy, host defense mechanism: review of clinical immunology, infectious diseases, and pediatric dermatology.

The meeting format also will embrace plenary sessions, 30 round-table discussions, and family programs. Subjects for the round-table discussions will include endocrinology, pediatric pulmonary medicine review, pneumonia and bronchiolitis, infectious diseases, the complement system, ophthalmology, otolaryngology, outpatient management of children with allergies,

gynecologic infections in pediatric patients, pulmonology, and pediatric dermatology.

No advance registrations later than March 16 will be accepted. For registration and other information, contact American Academy of Pediatrics, P. O. Box 1034, Div. M, Evanston, Illinois 60204.

## State Blood Banks Group To Meet In April

The fourth annual meeting of the West Virginia Association of Blood Banks will be held at Camden-Clark Hospital in Parkersburg April 11-12.

Officers of the WVABB are Echols A. Hansbarger, Jr., M. D., St. Francis Hospital, Charleston, President; Dennis O'Conner, M. D., St. Mary's Hospital, Huntington, President Elect; Judy Fertile, M. T. (ASCP), Camden-Clark Hospital, Vice President, and Helen Marie Gragg, M. T. (ASCP,) West Virginia University Medical Center, Morgantown, Secretary-Treasurer.

# *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*The Courage to Live*, by Ari Kiev, M. D. 148 pages. Price $7.95. Thomas Y. Crowell, Publishers, 10 East 53rd Street, New York, New York 10022. 1979.

*The Nervous System, 2nd Edition*, by William F. Ganong, M. D. 243 pages. Price $11. Lange Medical Publications, Los Altos, California 94022. 1979.

*Current Surgical Diagnosis and Treatment, 4th Edition*, by J. Englebert Dunphy, M. D., and Lawrence W. Way, M. D. 1162 pages. Price $19. Lange Medical Publications, Los Altos, California 94022. 1979.

*What You Should Know About Medical Lab Tests*, by Bernard Kliman, M. D., and Raymond Vermette, M. S., with Ernest Kolowrat. 201 pages. Price $9.95. Thomas Y. Crowell Company, 10 East 53rd Street, New York, New York 10022. 1979.

# *Medical Meetings*

Feb. 6-10—Am. College of Psychiatrists, San Antonio.

Feb. 7-12—Am. Academy of Orthopedic Surgeons, Atlanta.

Feb. 16-20—Am. Academy of Allergy, Atlanta.

Feb. 29-March 1—Va. Chapter, Am. Academy of Pediatrics, Williamsburg, Va.

March 9-13—Am. College of Cardiology, Houston.

March 19-21—Am. Society for Clinical Pharmacology & Therapeutics, San Francisco.

March 23-27—Am. College of Surgeons, Toronto.

April 2-8—Am. College of Allergists, Washington, D. C.

April 10-11—W. Va. Chapter, Am. Academy of Pediatrics, Charleston.

April 11-12—W. Va. Assn. of Blood Banks, Parkersburg.

April 11-12—33rd. Annual Stoneburner Lecture Series, Med. College of Va., Richmond.

April 17-18—Rural Health Conference, Boston.

April 17-20—Mo. State Med. Assn., Jefferson City.

April 18—Mood Disorders in Children (Children's Hospital National Medical Center and George Washington University Med. Center), Washington, D. C.

April 18-20—Scientific Assembly, W. Va. Chapter, AAFP, Morgantown.

April 19-24—Am. Academy of Pediatrics, Las Vegas.

April 20-23—W. Va. Academy of Ophthalmol. & Otolaryngol., White Sulphur Springs.

April 21-25—Am. Roentgen Ray Society, Las Vegas.

April 24-26—76th Congress on Med. Education, Chicago.

April 28-30—Southeastern Surgical Congress, Atlanta.

April 28-30—Am. Assn. for Thoracic Surgery, San Francisco.

April 28-May 2—Am. Pediatric Society, San Antonio.

April 30-May 2—Med. & Chirurgical Faculty of the State of Md., Hunt Valley, Md.

May 1-3—W. Va. Chapter, ACS, White Sulphur Springs.

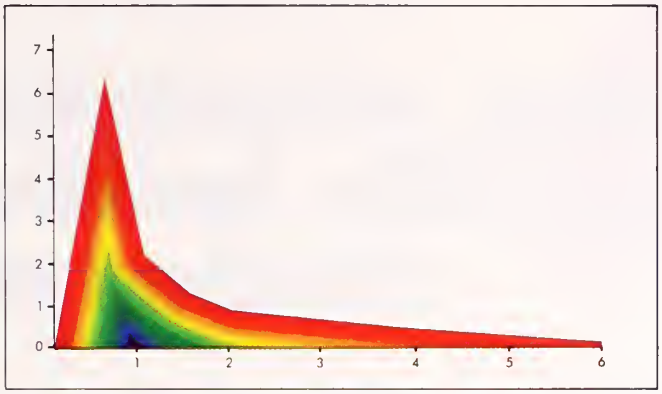
May 5-8—Am. College of Obstetricians & Gynecologists, New Orleans.

May 10-15—Ohio State Med. Assn., Cincinnati.

May 18-21—Am. Thoracic Society, Washington, D. C.

**Aug. 20-23—113th Annual Meeting, W. Va. State Assn., White Sulphur Springs.**

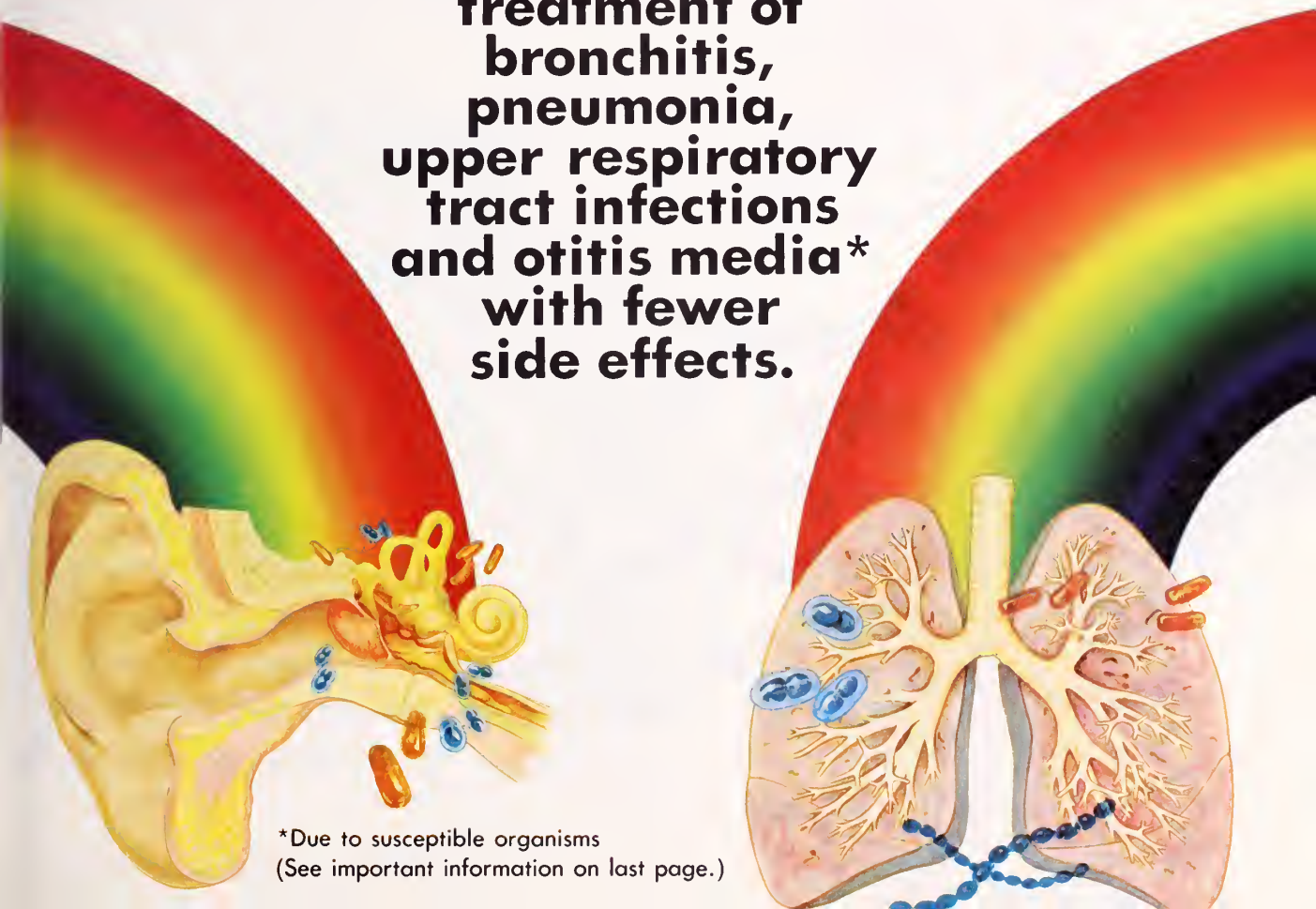
# more than just spectrum




# New CYCLAPEN®

## (cyclacillin) Tablets/ Suspension

**Efficacy proven in the treatment of bronchitis, pneumonia, upper respiratory tract infections and otitis media* with fewer side effects.**



*Due to susceptible organisms
(See important information on last page.)

# New CYCLAPEN®

## (cyclacillin) Tablets/ Suspension

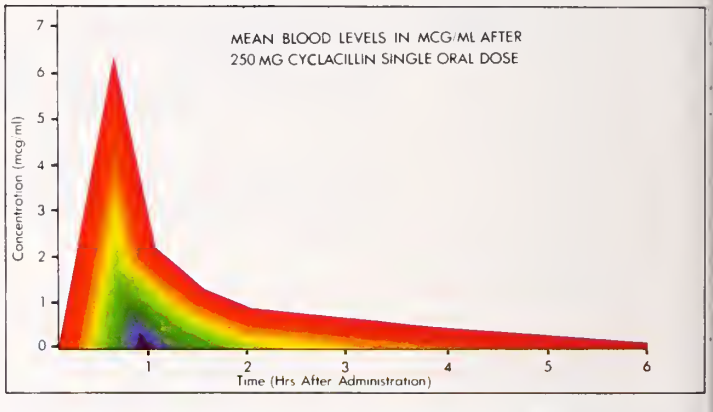
# efficacy with fewer side
# ampicillin confirmed in
# studies of 2,581

Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin




| High cure rate with CYCLAPEN® | | |
|---|---|---|
| Causative Organism | Bronchitis/Pneumonia† | No. of Patients |
| *S. pneumoniae* | 100 | 73 |
| | 95 | |
| Chronic Bronchitis† (acute exacerbation) | | |
| *H. influenzae* | 92 | 12 |
| | Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae* | |
| Streptococcal Sore Throat† | | |
| Group A beta-hemolytic Streptococcus | 100 | 44 |
| | 86 | |
| % Clinical Response | | |
| % Bacterial Eradication | | |

## more than just spectrum in bronchitis, pneumonia and upper respiratory tract infections†

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

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# effects than double-blind patients*

Fewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

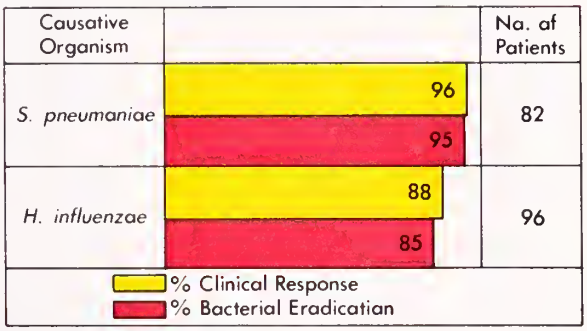
| Total number of drug-related side effects in all patients | |
|---|---|
| CYCLAPEN® | 128 of 1,286 (10%) of patients |
| ampicillin | 202 of 1,129 (18%) of patients |
| Difference statistically significant (P <0.001) | |

CYCLAPEN® (cyclacillin)
Effective for bronchitis, pneumonia, and upper respiratory tract infections†

- Excellent clinical results in bronchitis, pneumonia and upper respiratory tract infections
- Significantly lower incidence of diarrhea and skin rash

## more than just spectrum in otitis media

Clinical efficacy of CYCLAPEN® in otitis media†





1. Gald JA, Hegarty CP, Deitch MW, Walker BR: Dauble-blind clinical trials af aral cyclacillin and ampicillin, *Antimicrab Ag Chemather* 15:55-58, (Jan.) 1979.
2. Data an file, Wyeth Laboratories.


# more than just spectrum CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Wyeth Laboratories
Philadelphia, Pa 19101

(See important information on next page)

New from Wyeth Laboratories

# CYCLAPEN®

## (cyclacillin) Tablets/ Suspension

## more than just spectrum in bronchitis, pneumonia, upper respiratory tract infections and otitis media*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

### How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

**Indications**

*Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below*

Cyclapen® is indicated for the treatment of the following infections

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis* (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

**Contraindications**

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

**Warnings**

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN. ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

**Precautions**

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

**Adverse Reactions**

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS).

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

**Dosage and Administration**

| INFECTION* | ADULTS | CHILDREN |
|---|---|---|
| | | Dosage should not result in a dose higher than that for adults. |
| *Respiratory Tract* | | |
| Tonsillitis & Pharyngitis** | 250 mg q.i.d. in equally spaced doses | body weight <20 kg (44 lbs): 125 mg q.i.d. in equally spaced doses<br>body weight >20 kg (44 lbs): 250 mg q.i.d. in equally spaced doses |
| Bronchitis and Pneumonia | | |
| Mild or Moderate Infections | 250 mg q.i.d. in equally spaced doses | 50 mg/kg/day q.i.d. in equally spaced doses |
| Chronic Infections | 500 mg q.i.d. in equally spaced doses | 100 mg/kg/day q.i.d. in equally spaced doses |
| *Otitis Media* | 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity | 50 to 100 mg/kg/day in equally spaced doses depending on severity |
| *Skin & Skin Structures* | 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity | 50 to 100 mg/kg/day in equally spaced doses depending on severity |
| *Urinary Tract* | 500 mg q.i.d. in equally spaced doses | 100 mg/kg/day in equally spaced doses. |

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

*Patients with Renal Failure*

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of <10 ml/min or serum creatinine values of >10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

**Wyeth Laboratories**
Philadelphia, Pa 19101

# THE WHEELING CLINIC

**EOFF AT 16th STREET**

## WHEELING, WEST VIRGINIA

**General Surgery:**
John O. Rankin, M. D.
Charles D. Hershey, M. D.
Edward C. Voss, M. D.

**Ophthalmology:**
William F. Park, M. D.
Milton E. Nugent, M. D.
Rizal V. Pangilinan, M. D.

**Ear, Nose & Throat:**
Wilfredo A. Tiu, M. D.

**Orthopedic Surgery:**
Edgar L. Barrett, M. D.
Richard S. Glass, M. D.

**Thoracic Surgery:**
Daniel W. Dickinson, M. D.

**Obstetrics and Gynecology:**
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Terry Athari, M. D.
James W. Campbell, M. D.

**Urology:**
Donald C. Trapp, M. D.
John P. Franz, M. D.

**Dermatology:**
K. William Waterson, M. D.

**Internal Medicine:**
Albert M. Valentine, M. D.
Carlos A. Vasquez, M. D.
Thomas E. Chvasta, M. D.
Byron L. VanPelt, M. D.
Paul R. Hedges, M. D.
T. Gary Kenamond, M. D.
Derrick L. Latos, M. D.
William E. Noble, M. D.

**Psychiatry:**
David H. Smith, M. D.
Stephen D. Ward, M. D.
David Hill, M. D.

**Neurology:**
Albert L. Wanner, M. D.
Henry L. Kettler, M. D.
Srini Govindan, M. D.

**Roentgenology:**
Drs. Butler, Aceto & Assocs.

**Speech Pathologist and Audiologist:**
James P. Frum, M. S.

**Clinical Laboratories:**
Donna Burlenski
Donna Bryan

**Physician Assistants:**
Joann Green, P. A.
Michael G. Simon, P. A.

**Technologists:**
Electrocardiography:
Betty Maguire, R. N.
Brenda Muklewicz, R. N.
Electroencephalography:
Juanita Stone, R. N.
Roentgenology:
Evelyn Forester, R. T.

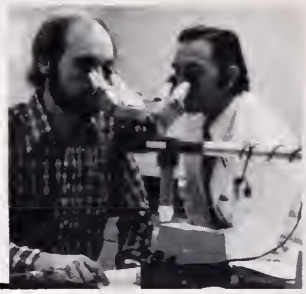
**Administration:**
Lester L. Cline,
Executive Director
Douglas G. Anderson,
Business Manager
Henry L. Castilow,
Asst. Business Manager

# Saint Albans Psychiatric Hospital

An accredited private nonprofit psychiatric hospital for the treatment of all major psychiatric illnesses, including alcoholism and drug abuse, of adults and adolescents.

Radford, Virginia 24141
Telephone 703 639 2481

# WVU Medical Center
# —News—



*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## Study Of Patients At Pain Clinic Completed

Reconciliation to suffering as a way of life is not characteristic of three out of four chronic pain patients, nor do they see themselves as frequently ill or sickly.

Depressed at some time about their pain problems and their inability to function at previous levels, they nevertheless do not consider themselves depressed in general.

These conclusions are among those drawn from a computerized study of the first 200 patients at WVU Hospital's Outpatient Clinic Center for Pain Control for a year beginning in July, 1978. These patients were asked to complete a 150-item questionnaire, with answers to about 100 of the questions being fed into the computer. The resulting data was analyzed to establish demographic, socio-economic, physiologic, psychologic and therapeutic aspects common to the problem of chronic pain.

Results of the study have been reported at several professional meetings by Robert Bettinger, M. D., Assistant Professor of Anesthesiology and Director of the Center for Pain Control, and Robert E. Pawlicki, Ph.D., Associate Professor of Behavioral Medicine and Psychiatry. Other faculty involved with the study include Richard B. Knapp, M. D., Professor and Chairman of Anesthesiology, and David F. Colvin, M. D., Assistant Professor of Behavioral Medicine and Psychiatry.

The patients, drawn largely from a rural population, included 105 men with a median age of 45.4 and 95 women whose median age was 50.9. Most had experienced pain for more than one year. Onset of pain occurred earlier in the men—30-39 as compared with 40-49 years for the women. Researchers believe the difference is attributable to work-related injuries in the men.

The average number of operations was less than one per patient with only half of those having surgery stating that the procedure was effective in relieving pain. Of the 65 individuals who had nerve blocks for pain, only 30 per cent reported benefit.

Only half of the 35 patients who had received some psychiatric treatment thought they had been helped.

## Reviews Of Drug Use Show Dilemma Of Elderly

Deteriorating body functions and organ systems, multi-drug therapy and lack of understanding are primary factors contributing to the drug dilemma of the elderly, according to an associate professor of clinical pharmacy at the WVU Medical Center.

Tim R. Covington, Pharm. D., who has conducted extensive reviews of geriatric drug use, said that innovations in drug therapy over the past 30 years have undoubtedly increased life expectancy. But these same drugs can damage the quality of that prolonged life unless they are properly used.

There are several physiological factors which make drug use in the elderly an area of special concern, Doctor Covington said. Primarily affected are the absorption, distribution, metabolism and excretion of drugs.

"The aged are absolutely more sensitive than others to the effects of drugs, although the reasons for this are not always fully understood. They are, for example, hypersensitive to morphine and other opiate derivatives such as codeine. From these drugs the aged can expect more than the 'normal' amount of sedation, mental confusion and lack of coordination. The elderly are also generally more sensitive to frequently prescribed tranquilizers such as Valium and Librium."

# Prince Medical Reference Laboratories

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CLINICAL PATHOLOGY

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PARTICIPANT
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TESTING PROGRAMS
OF CDC, CAP and
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# Third-Party News, Views and Program Concerns

## Compensation Fund Moves To Simplify Procedures

The State Workmen's Compensation Fund continues to make significant progress toward simplifying the pre-authorization procedure required for claims processing and payment. At this writing, a new "request for authorization" form to be available to all of West Virginia's practicing physicians was in the hands of the printer.

This three-part form will originate in the physician's office, eliminating the necessity for dictating a letter of request for authorization. The majority of the form can be completed by office personnel, but must be signed by the physician.

The third copy is to be retained by the physician requesting authorization, thus eliminating duplicating cost for the physician's office. The first two copies are to be mailed to Workmen's Compensation, where, through "special" handling, the new "request for authorization" will be granted, denied, or granted subject to compensability. A copy then will be returned to the requesting physician. This complete procedure should take no longer than a week to 10 days.

Any questions concerning this procedure, or requests for the new forms, can be directed to Mr. Joseph I. Stone, Administrative Assistant for Claims Processing, West Virginia Workmen's Compensation Fund, State Capitol, Charleston 25305; telephone 348-5940.

(*The form is reproduced on adjoining page.*)

## HEW Conducting Campaign For Second Opinions

A campaign to encourage people to get second opinions before elective surgery is being conducted by HEW's Health Care Financing Administration. "We believe our informative campaign can improve the quality of health care and help reduce unnecessary surgery," said HEW Secretary Patricia Harris. "We want people to be aware that they have a right to get all the facts about their particular medical problems, including whether or why surgery is necessary, advisable or avoidable," she said. The campaign includes radio and television announcements, brochures, posters, and a toll-free telephone hot line through which patients can get the names of physicians willing to give second opinions.

Commenting on the HEW campaign, American Medical Association Executive Vice President James H. Sammons, M. D., said the AMA has always encouraged patients and physicians to seek consultations when either one is unsure of a diagnosis. "But to encourage patients to automatically seek a second opinion to determine the appropriateness of 'non-emergency' surgery is to encourage yet higher health care costs without necessarily providing improved quality in care," he added.

Doctor Sammons pointed out that there is little evidence to support the view that second opinion programs are cost-effective, since reported savings seldom take into consideration the cost of an alternative medical treatment or the number of delayed operations which are eventually performed.

## Artificial Sweeteners—Bladder Cancer Relationship?

The National Cancer Institute (NCI) and the Food and Drug Administration (FDA) recently released the preliminary findings of a $1.5 million epidemiological study that examined the relationship between the use of artificial sweeteners such as saccharin and cyclamate and the incidence of bladder cancer in humans.

The preliminary results of the study conducted by NCI were that there was no increased risk of bladder cancer among users of artificial sweeteners in the overall study population. However, there was some evidence that sweeteners may be hazardous for heavy users of artificial sweeteners, and for people who smoked cigarettes heavily and who also made heavy use of artificial sweeteners.

WC-212
1-8-80

(See first story on adjoining page.)

# REQUEST FOR AUTHORIZATION

CLAIMANT'S/PATIENT'S NAME: _____

CLAIM NUMBER | SOCIAL SECURITY NUMBER | DATE OF INJURY

Diagnosis: _____

FROM: _____
_____
_____

(Name and address of physician or vendor requesting authorization)

TO: West Virginia Workmen's Compensation Fund
P.O. Box 3151
Charleston, West Virginia 25332

ATTENTION: ☐ Medical Division
☐ Rehabilitation Services Division

Authorization is hereby requested from the Workmen's Compensation Fund to:

☐ Hospitalize the claimant/patient at _____ Hospital for a period of _____ days for _____

☐ Perform surgery on the claimant/patient consisting of _____ _____; surgery to be carried out at _____ Hospital on an ☐ inpatient ☐ outpatient basis.

☐ Provide the claimant/patient with _____ (no. requested) physical therapy treatments consisting of _____ _____

☐ Provide the claimant with _____ medical treatments consisting of _____ _____

☐ Refer claimant/patient to _____ (name of physician, therapist, hospital) a(n) _____ (speciality) for further evaluation or treatment consisting of _____

☐ Perform a myelogram on the claimant/patient.

☐ Refer the claimant to _____ for a TENS Unit.

☐ Refer the claimant to an amputee clinic at _____ for evaluation and fitting of a prosthesis.

☐ Refer the claimant to a rehabilitation center at _____ (name and location) for further management of the injury.

☐ Other (please specify) _____ _____

I hereby certify that the services requested herein are, to the best of my knowledge, necessitated as a direct result of the claimant's injury. A report covering the treatment and/or services rendered and the results obtained therefrom will be submitted to the Commissioner within a reasonable period of time.

Signature _____

**********

FOR FUND USE ONLY

TO: _____

FROM: West Virginia Workmen's Compensation Fund, ☐ Medical Division ☐ Rehabilitation Services Division

☐ Authorization is granted as requested above.

☐ Authorization is denied for the following reason(s) _____ _____

☐ Authorization is granted subject to finding of compensability.

AUTHORIZATION GRANTED BY: _____
(Title)

# Obituaries

### O. M. HARPER, M. D.

Dr. O. M. Harper, Clendenin family physician since 1937, was killed on December 15 when his car hit a rock and went into the Elk River near Clendenin. He was 78.

A native of Roane County, Doctor Harper was graduated from Alice Lloyd College in Pippa Passes, Kentucky, and received his M. D. degree in 1931 from the University of Louisville. He interned at Charleston General Hospital.

He practiced in Swandale (Clay County) before going to Clendenin.

Doctor Harper was an honorary member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

A member of the American Rose Society, he was nationally-known for prizes he won in rose-growing competition.

Survivors include the widow; three brothers, Clyde Harper of Zephyr Hills, Florida; Tom Harper of Harmony (Roane County), and Russell Harper of Gandeeville (Roane County); and three sisters, Mrs. Hazel Bohn of Willard, Ohio; Mrs. Freda Mays of Ravenswood, and Mrs. Ava Poling of Kentuck (Jackson County).

* * *

### WILLIAM C. KAPPES, M. D.

Dr. William C. Kappes, retired Huntington surgeon, died on December 12 in a hospital there. He was 80.

Doctor Kappes was the first Chief of Staff of Cabell-Huntington Hospital in Huntington.

He was a former member and President of the Cabell County Medical Society, and a former member of the West Virginia State Medical Association and American Medical Association.

A Kappes Scholarship Fund has been established in his memory at the Marshall University Medical School.

Survivors include two sons, Dr. William C. Kappes, Jr., of Waynesboro, Virginia, and Dr. Charles K. Kappes of Cincinnati.



**Quinamm**™

**AVAILABLE ONLY ON PRESCRIPTION**

**Brief Summary**

**INDICATIONS:** For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

**CONTRAINDICATIONS:** Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

**PRECAUTIONS:** Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

**ADVERSE REACTIONS:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued

**DOSAGE AND ADMINISTRATION:**
1 tablet upon retiring When necessary, 1 additional tablet may be taken following the evening meal

Product Information as of September, 1977

U S Patent 2,985,558

**Merrell**

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cimetidine/2ml.
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cimetidine
hydrochloride
SK&F LAB CO.
SKF
T13
Tagamet®
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cimetidine
How Supplied:
Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).
Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.
SK&F LAB CO.
a SmithKline company

# When painful spasm is the presenting symptom...

...in the functional bowel/irritable bowel syndrome*

# Bentyl®

## (dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.

Pylorospasm has almost totally blocked passage of barium meal.

Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

*"The correlation of spasm relief and drug given was excellent."*

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964

**Merrell**

8-4420 (Y736A) MNR-804

# Bentyl®

## (dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS
For use in the treatment of infant colic (syrup)
Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with Autonomic neuropathy Hepatic or renal disease Ulcerative colitis Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition
Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness, dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations, some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs
*Usual Dosage* Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water) Bentyl 20 mg *Adults* 1 tablet three or four times daily Bentyl Injection *Adults* 2 ml (20 mg) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used
Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U S A

**Merrell**

MERRELL NATIONAL LABORATORIES
Division of Richardson Merrell Inc
Cincinnati Ohio 45215 U S A



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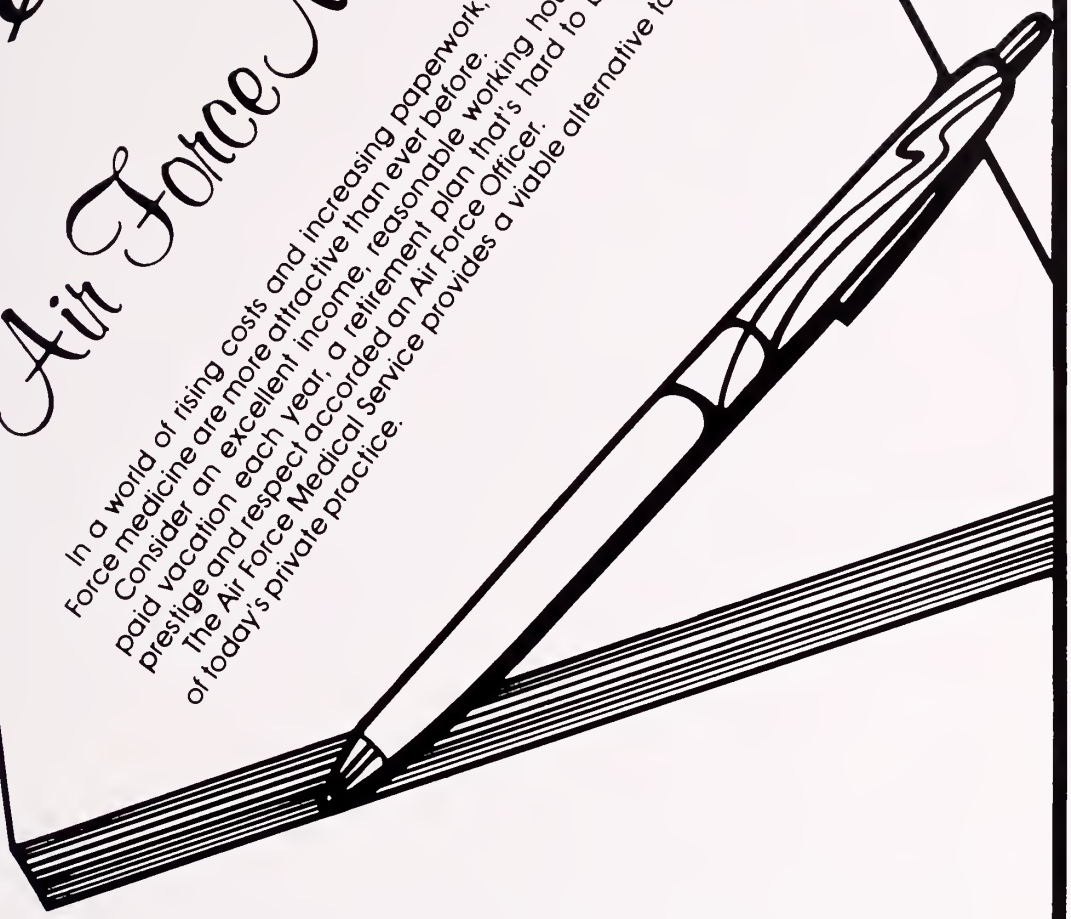

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# V-Cillin K®

## penicillin V potassium

## is the most widely prescribed brand of oral penicillin

Tablets
125, 250, and 500 mg*
Oral Solution
125 and 250 mg*/5 ml

**V-Cillin K®**
**penicillin V potassium**

**Description:** V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

**Indications:** For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

**Contraindication:** Previous hypersensitivity to penicillin.

**Warnings:** Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

**Precautions:** Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

**Adverse Reactions:** Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

***Equivalent to penicillin V.**

*Additional information available to the profession on request.*

Lilly
Eli Lilly and Company
Indianapolis, Indiana 46206

900416

# Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

## specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease . . . consider Quinamm . . . simple, convenient dosage—usually just one tablet at bedtime . . . can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.

# Alpha Stimulation

## Central Control of Blood Pressure*

The Family of Man by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres

# The Alpha Advantage:

## It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

| | |
|---|---|
| Congestive heart failure | Allergic rhinitis |
| Ventricular hypertrophy | Hepatic disease |
| Hyperglycemia | Hyperuricemia |
| Diabetes mellitus | Gouty arthritis |
| Bronchial asthma | Sulfonamide hypersensitivity |

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

**work/play**—normal hemodynamic responses to exercise maintained.

**love**—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

**cardiac output**—tends to return to control values during long-term therapy.

**blood flow**—preserved in kidney.

*No Single Advantage Determines Drug Choice.*

Other factors must include:

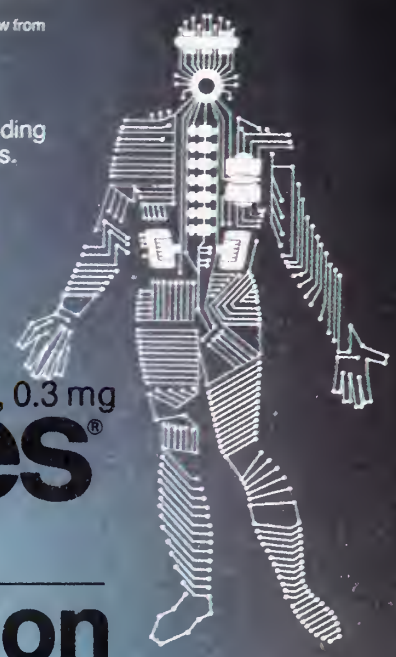
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain as shown in animal studies.

[1] Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

**Now available in new 0.3 mg tablets**



Tablets of 0.1, 0.2, 0.3 mg

# Catapres®
## (clonidine HCl)
## Hypertension

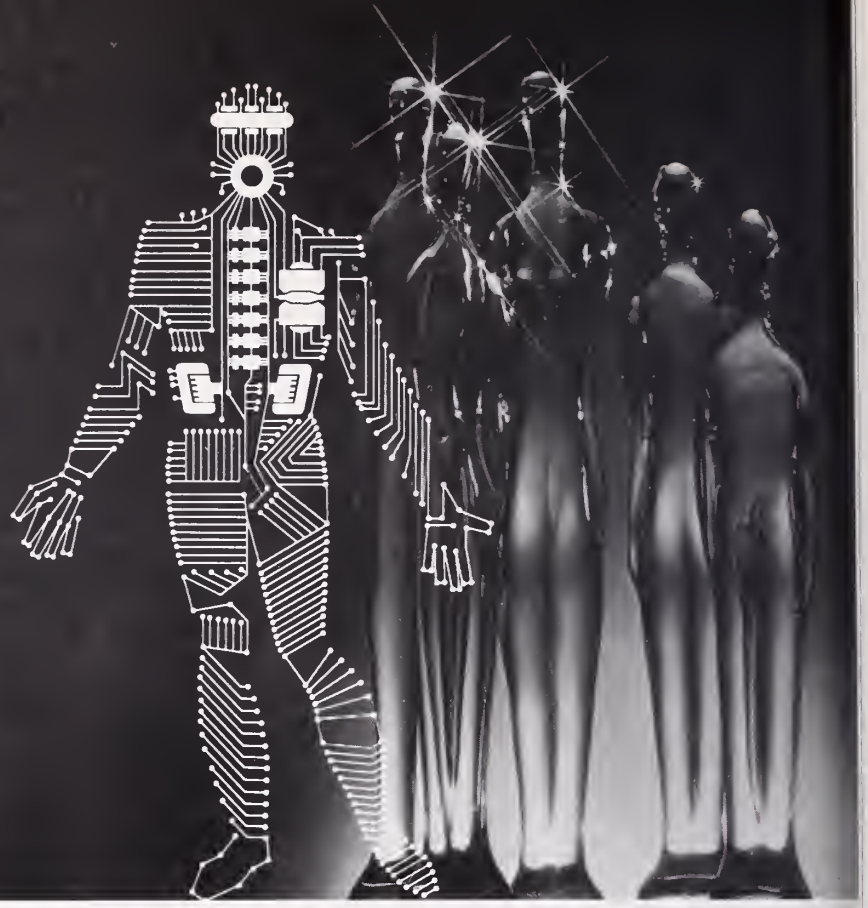
# The Alpha Advantage:

## It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

**Catapres®**
(clonidine HCl)

**Hypertension**



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

**Catapres®**
**(clonidine hydrochloride)**
**Tablets of 0.1, 0.2, 0.3 mg**

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
*Usage in Children:* No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

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**Boehringer Ingelheim**

Boehringer Ingelheim Ltd.
Ridgefield, CT 06877

# County Societies

## CABELL

The Cabell County Medical Society met on December 14 at the Guyan Country Club for the annual Christmas Dinner Dance.

Dr. Stephen D. Ward of Wheeling, President of the West Virginia State Medical Association, and Mrs. Ward were our special guests.

Doctor Ward described the place of organized medicine and the American Medical Association at this time.

Members of the Society observed silent tribute in memory of two recently-deceased members, Drs. William C. Kappes and J. Foster Carr.—Charles E. Turner, M. D., Secretary.

* * *

## McDOWELL

A Christmas banquet was held by the McDowell County Medical Society on December 9 in Welch at Raymond's Catering Inn.

Dr. Bernard M. Swope, the outgoing President, introduced the new officers for 1980, and gave a talk on the history of the Society.—Muthusami Kuppusami, M. D., Secretary.


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## OFFICERS OF COMPONENT SOCIETIES

| Society | President | | Secretary | | Meetings |
|---|---|---|---|---|---|
| Boone | George H. Cook | Whitesville | Harold H. Howell | Madison | 3rd Wed. |
| Brooke | Rogelio L. Velarde | Follansbee | Wm. T. Booher, Jr. | Wellsburg | |
| Cabell | Harry K. Tweel | Huntington | Charles E. Turner | Huntington | 2nd Thurs. |
| Central West Virginia | John A. Mathias | Buckhannon | Joseph B. Reed | Buckhannon | As Sched. |
| Eastern Panhandle | Harvey D. Reisenweber | Martinsburg | Orlando I. Agnir | Martinsburg | 2nd Wed. |
| Fayette | Lewis A. Cook | Fayetteville | Daniel B. Doyle | Oak Hill | 1st Wed. |
| Greenbrier Valley | Robert K. Modlin | Ronceverte | Robert K. Scott II | Ronceverte | 2nd Wed. |
| Hancock | Carlos L. Vasquez | Weirton | Pedro R. Montero, Jr. | Weirton | 3rd Tues. |
| Harrison | Louis C. Palmer | Bridgeport | Victorino D. Chin | Bridgeport | 1st Thurs. |
| Jefferson | L. Mildred Williams | Charles Town | Vittivelu Maheswaran | Charles Town | 1st Wed. |
| Kanawha | James W. Lane | Charleston | Thomas J. Janicki | Charleston | 2nd Tues. |
| Logan | Abelard A. Pelaez | Logan | Herbert D. Stern | Logan | 2nd Wed. |
| Marion | Charles E. Haislip | Fairmont | Wm. L. Mossburg | Fairmont | Last Tues. |
| Marshall | Erol Bastug | Glen Dale | J. T. Ho | Moundsville | 1st Tues. |
| Mason | Montrie Chaksupa | Point Pleasant | Richard L. Slack | Point Pleasant | 4th Tues. |
| McDowell | Cheryl Lynn Linkous | Welch | M. Kuppusami | Welch | 2nd Wed. |
| Mercer | Edward M. Spencer | Bluefield | David F. Bell, Jr. | Bluefield | 3rd Mon. |
| Mingo | William H. Carter | Williamson | Edward B. Headley | Delbarton | 2nd Wed. |
| Monongalia | Barbara Jones | Morgantown | Richard S. Kerr | Morgantown | 1st Tues. |
| Ohio | Basil P. Papadimitriou | Wheeling | Mr. Henry L. Castilow | Wheeling | 4th Tues. |
| Parkersburg Academy | Robert F. Gustke | Parkersburg | Billie M. Atkinson | Parkersburg | 1st Thurs. |
| Potomac Valley | Howard J. Maxwell | Petersburg | Sadtha Surattamont | Romney | 2nd Wed. |
| Preston | John W. Trenton | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | Prospero B. Gogo | Beckley | Richard D. Richmond | Beckley | 3rd Thurs. |
| Summers | E. L. Jimenez | Hinton | Chandra P. Sharma | Hinton | 3rd Mon. |
| Tygart's Valley | A. Kyle Bush | Philippi | Michael M. Stump | Elkins | 3rd Thurs. |
| Wetzel | K. M. Chengappa | New Martinsville | Donald A. Blum | New Martinsville | Monthly |
| Wyoming | George F. Fordham | Mullens | Frank J. Zsoldos | Mullens | Quarterly |

## PHYSICIANS NEEDED

**General Practice/Family Practice/Internist**—We are currently recruiting for placement in our clinics (four) for July 1, 1980 openings. We are located in rural southern West Virginia and have an excellent statewide reputation. Salaries are negotiable and benefits include paid vacation, study leave, malpractice insurance, moving expenses. Also available are tax sheltered annuities and pension plan. We are seeking physicians who would like to grow with our system and are willing to accept responsibility for practice development. If you think you may be interested, please contact Hygeia Facilities Foundation, P. O. Box 217, Whitesville, West Virginia 25209, Attn.: Administrator.

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## OPPORTUNITY AVAILABLE

Senior Physician for Center for the Mentally Retarded. Supervises the delivery of quality medical services for 900 retarded children and adults. Duties include supervision of seven physicians, consultation and professional liaison with other service providers. Must be licensed to practice in Virginia. Salary range $33,400-$51,700, liberal state benefits, good working environment.

Contact: Mr. James A. Easter, Personnel Office, Southside Virginia Training Center, Petersburg, VA 23803. Telephone: (804) 861-7493.

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Preferably a Board Certified Internist, is needed to fill a career post in Charleston. We offer a competitive salary, generous fringe benefits, regular hours and ample vacation time. A voluntary hospital teaching assignment is encouraged. Interested physicians should send their curriculum vitae to A. G. Bickelmann, M. D., Corporate Medical Director, C&P Telephone Company, 1710 H Street, N. W., Washington, D. C. 20006.

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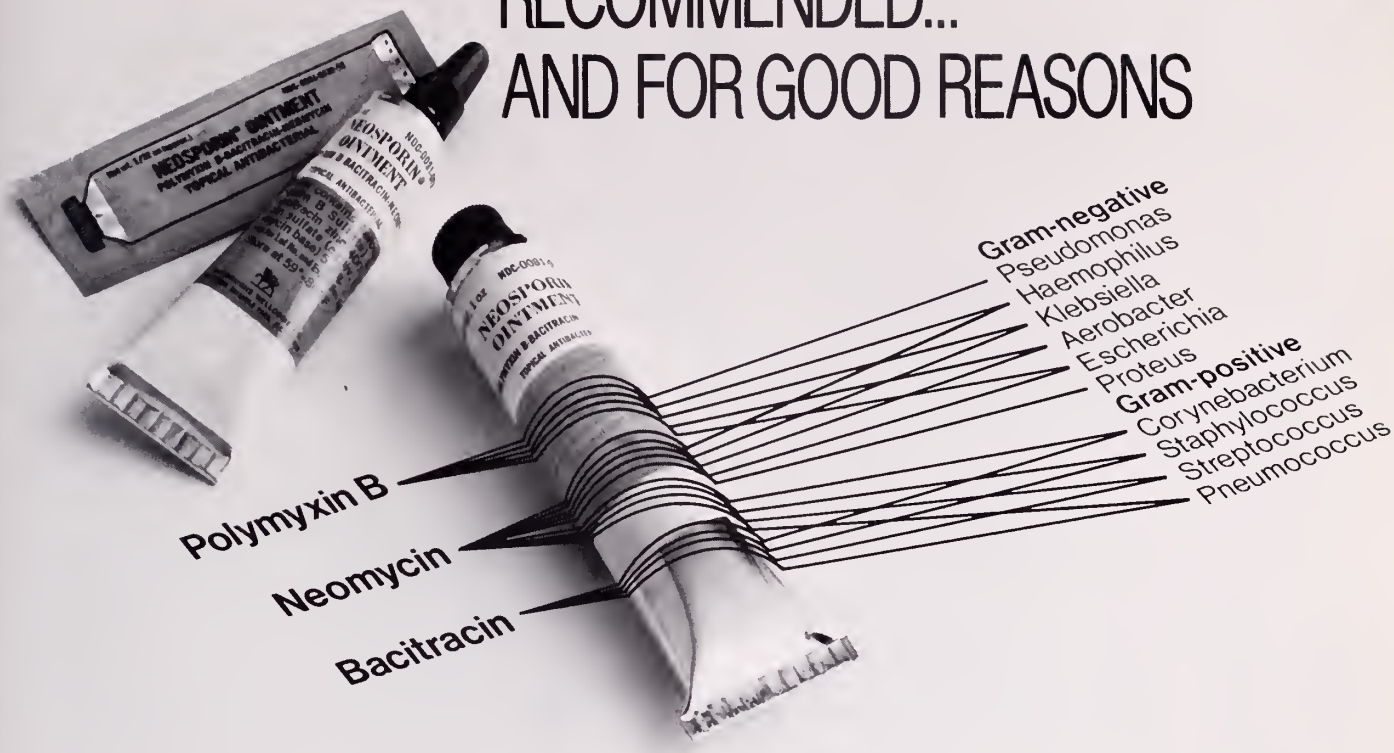


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**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

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**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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113th ANNUAL MEETING

of the

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## *The Greenbrier*

AUGUST 20-23, 1980

# PLAN NOW TO ATTEND

# Health and Safety Tip

From the American Medical Association

535 North Dearborn Street/Chicago, Illinois 60610

## High Blood Pressure Affects Many Adults

## Combat Big Killer

An estimated 23 million Americans — 20 per cent of the adult population — have high blood pressure. Only about half of these individuals know they have high blood pressure, and only a minority of those who do know are being treated effectively.

Why do so many of us ignore this serious health hazard? Everyone knows that high blood pressure is bad for our health. Why don't we have blood pressure checked regularly? Why don't we begin treatment when the blood pressure is too high?

Because high blood pressure is a silent disease. Unless you have seen a doctor, you don't know you have it. And, even after you find out, it doesn't hurt. So why bother?

High blood pressure is one of the great killers. It can shorten your life by contributing to failure of your heart, arteries, kidneys and brain, the American Medical Association declares.

A nationwide screening effort has been underway for several years in America to locate those persons with high blood pressure and get them started on treatment. High blood pressure can be controlled. And the result is a greatly lowered risk of serious disease and death.

Don't panic about your blood pressure, but protect your health and your life by keeping in mind five facts —

1. High blood pressure is a silent disease; it almost never has symptoms and a person does not feel sick.
2. It is a major cause of stroke, heart failure and kidney failure, but these disorders often can be prevented with control of high blood pressure.
3. It can be controlled by taking medications prescribed by your physician and by following his advice about life style.
4. High blood pressure medication should be taken every day, even if the patient feels well.
5. All adults, every one of us, should have blood pressure checked regularly.

It cannot be overemphasized that high blood pressure will not be cured, it will only be controlled. Thus it is vital to continue the therapy prescribed by the physician even after the blood pressure level has been lowered sufficiently. Abandon treatment and the pressure climbs again.

January, 1980
Frank Chappell
Science News Editor
AMA

## CLASSIFIED

**PSYCHIATRIST WANTED**—To fulfill the critical need in West Virginia Mental Institutions. Qualification: Board eligibility, with a desire to become Board Certified. MUST BE DEDICATED, ability to take the initiative, be productive, and work harmoniously with all personnel. Starting salary $40,000. Contact Arthur Schultz, Professional Services Coordinator, State Health Department, 1800 Washington Street, East, Charleston, WV 25305.

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**WANTED**—Physician to fulfill the critical needs in West Virginia's State Institutions. Qualification: A permanent license to practice medicine in West Virginia and three years of full-time paid experience. Starting salary $40,000. Contact Arthur Schultz, Professional Services Coordinator, State Health Department, 1800 Washington Street, East, Charleston, WV 25305.

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**RADIOLOGIST WANTED** — Temporary salaried position, minimum six months with possibility for extended employment if mutually satisfactory. Multi-hospital private practice, malpractice insurance paid, salary negotiable. Eligibility for Virginia license required. Curriculum vita first letter, please. Reply to FBC, P. O. Box 1031, Charleston, WV 25324.

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**PHYSICIAN WANTED**—An experienced practitioner to add to and work with an established group in Charleston. Excellent working conditions with regular hours and minimal night work. Liberal vacation, sick leave and holiday program. Pension plan, Social Security, and professional liability insurance coverage. Apply Charles E. Staats, M. D., 123 West Washington Street, Charleston, WV 25302 —Telephone: (304) 346-0381.

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**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician for 9 year old modern 80 bed hospital centrally located between Parkersburg and Charleston. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

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**WANTED**—A physician for the twin towns of Harpers Ferry and Bolivar, West Virginia—about 8 miles from Charles Town, where there is a hospital. Serving a population of 1500. Twin towns located in scenic mountain area, good fishing and Harpers Ferry National Park—approximately 1½ hours' drive from Washington, D. C. Contact Mr. Reid V. Geronimo, President Bolivar Civic Association, Route 1, Box 5, Harpers Ferry, WV 25425. Telephone: (304) 535-6528.

**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician for a modern 95-bed hospital. New emergency room facilities recently built. Excellent working conditions. Contact Patrick Smith, Assistant Administrator, Summers County Hospital, Hinton, WV 25951. Telephone: (304) 466-1000.

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**WANTED**—Board eligible or certified Obstetrician/Gynecologist needed for small town of 6,000. Modern hospital with latest equipment to work with available. Financial arrangements and office space negotiable. Contact J. N. Vallandingham, Administrator, Summers County Hospital, Hinton, WV 25951. Telephone: (304) 466-1000.

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**WANTED**—Board eligible or certified Orthopedic Surgeon needed for small rural community. Modern hospital to work in with clinic building located next to hospital. Financial arrangements and office space negotiable. Contact J. N. Vallandingham, Administrator, Summers County Hospital, Hinton, WV 25951. Telephone: (304) 466-1000.

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**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician to join a young, progressive E. R. group in southern West Virginia. Individual would join R. M. Cyphers, M.D. (West Virginia University Medical School, class of '72), at a 215-bed community hospital located in Princeton. Guaranteed income and excellent working conditions are available. Please contact Bill Clark, Associate Administrator, Princeton Community Hospital, Princeton, WV 24740. Telephone: (304) 425-2434.

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**PRACTICE OPPORTUNITIES** — Family physicians, internists and surgeons needed in an area with 16,000 population featuring excellent practice and recreational opportunities. Options of solo practice, or association with established groups. Excellent surgical suite in well-equipped 143-bed hospital. Contact Mr. John Moore, Administrator, Grafton City Hospital, Market Street, Grafton, WV 26354. Telephone: (304) 265-0400.

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**FAMILY PRACTICE OPENINGS** — Pendleton County offers the rural medical practice challenge you are seeking. Located in the picturesque Eastern Panhandle town of Franklin are a group of active and interested businessmen and citizens committed to recruiting and financially supporting the establishment of new practices. This opportunity is worth exploring! Contact George I. Sponaugle, President of Pendleton Industries, Franklin, WV 26807. Telephone: (304) 358-2337.

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**WANTED**—Ophthalmic Assistant-Technician. Forward curriculum to Saravut S. Fung, M. D., 537 Empire Bank Building, Clarksburg, WV 26301.

## CLASSIFIED

**WANTED**—Young physicians for a growing town with industry, a college and a good place to live. Town of 7,000, rural setting, pleasant surroundings, accessible to recreation. Openings for several family practitioners interested in obstetrics; and one internist. Contact Joseph B. Reed, M. D., 93 W. Main Street, Buckhannon, WV 26201. Telephone: (304) 472-6041.

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**WANTED**—Mountaineer Family Health Plan, a pre-paid primary care program needs a general/family practitioner or internist for ambulatory patient care. Facilities include two primary care centers; one urban and one rural. Licensure in West Virginia required. Salary negotiable with liberal fringe benefits. Call or write E. Christa Stern, Health Services Coordinator, 306 Stanaford Road, Beckley, WV 25801. Telephone: (304) 252-8551.

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**WANTED**—Physicians for growing northeastern West Virginia community with drawing population over 100,000. Excellent office facility complete with laboratory and radiology. Modern hospital nearby. Guaranteed income. Contact C. L. Dana, The W. Va. Medical Journal, P. O. Box 1031, Charleston, WV 25324.

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**WANTED** — Obstetrician/Gynecologist needed to take over existing practice in progressive community centrally located between Parkersburg and Charleston. Nine year old modern 80 bed hospital with latest equipment and facilities. Hospital is willing to negotiate financial arrangements and office space. Excellent opportunity for young physician wishing to establish active practice. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

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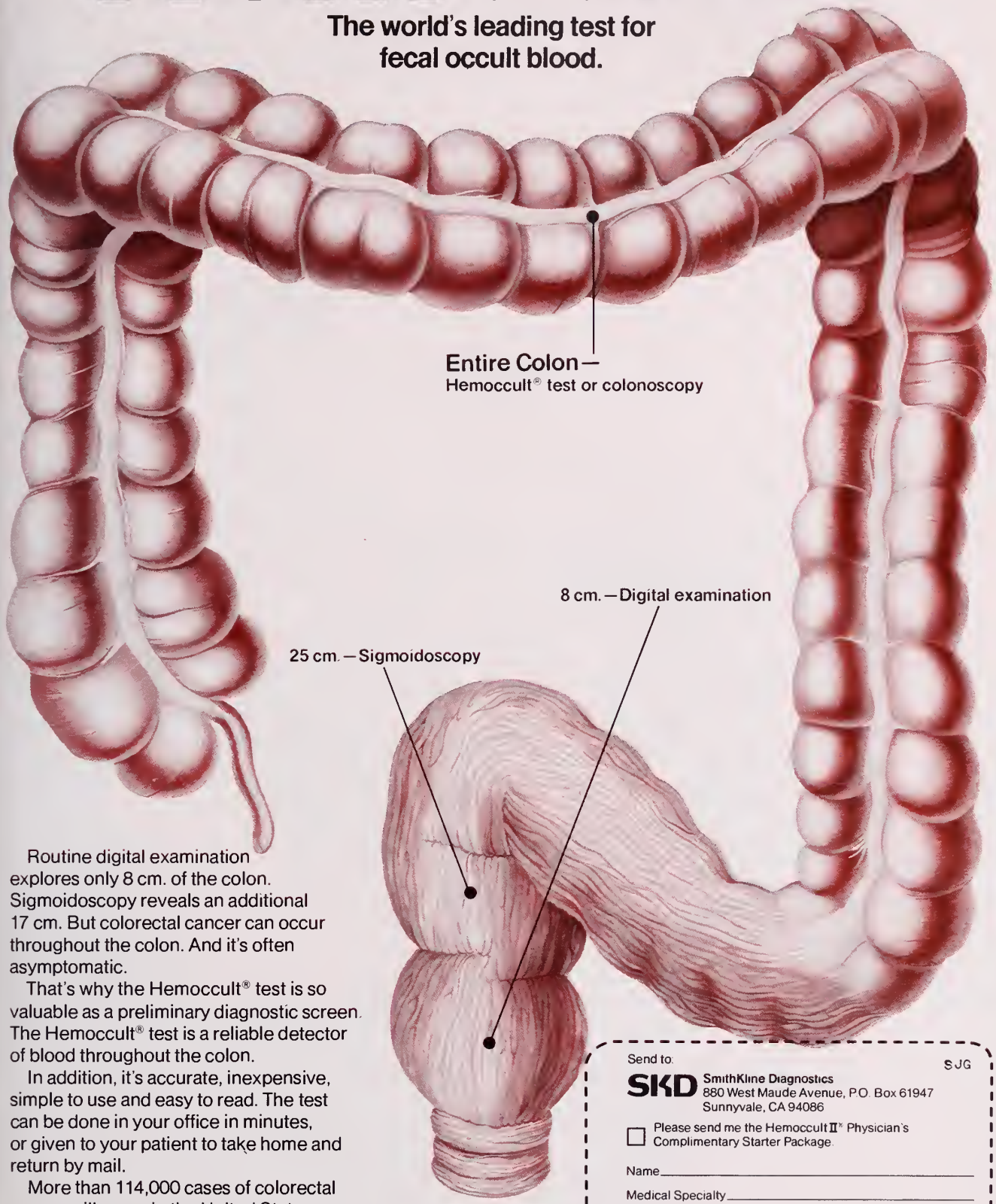


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...in the functional bowel/irritable bowel syndrome*

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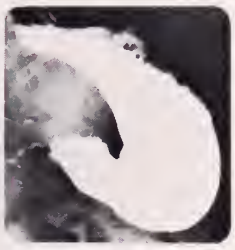

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Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964

# Merrell

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Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS
Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective
For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS
For use in the treatment of infant colic (syrup)
Final classification of the less-than-effective indications requires further investigation

CONTRAINDICATIONS Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis WARNINGS In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating) Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy In this instance treatment with this drug would be inappropriate and possibly harmful Bentyl may produce drowsiness or blurred vision In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug PRECAUTIONS Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy Use with caution in patients with Autonomic neuropathy Hepatic or renal disease Ulcerative colitis Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition
Do not rely on the use of the drug in the presence of complication of biliary tract disease Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate With overdosage, a curare-like action may occur ADVERSE REACTIONS Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response The physician must delineate these Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste; headache, nervousness, drowsiness, weakness, dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation DOSAGE AND ADMINISTRATION Dosage must be adjusted to individual patient's needs
*Usual Dosage* Bentyl 10 mg capsule and syrup *Adults* 1 or 2 capsules or teaspoonfuls syrup three or four times daily *Children* 1 capsule or teaspoonful syrup three or four times daily *Infants* ½ teaspoonful syrup three or four times daily (May be diluted with equal volume of water) Bentyl 20 mg *Adults* 1 tablet three or four times daily Bentyl Injection *Adults* 2 ml. (20 mg) every four to six hours intramuscularly only NOT FOR INTRAVENOUS USE MANAGEMENT OF OVERDOSE The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation Treatment should consist of gastric lavage, emetics, and activated charcoal Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used
Product Information as of October, 1978

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

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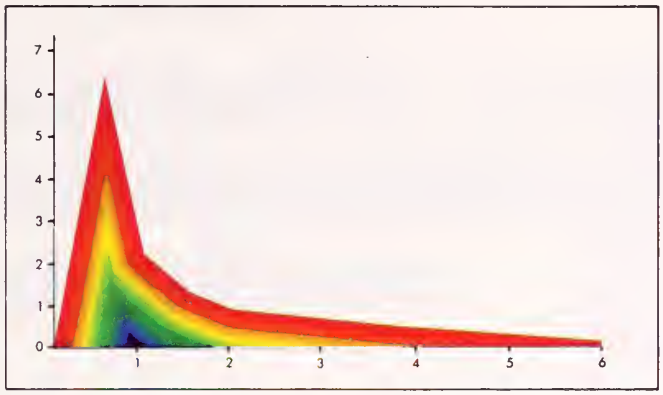
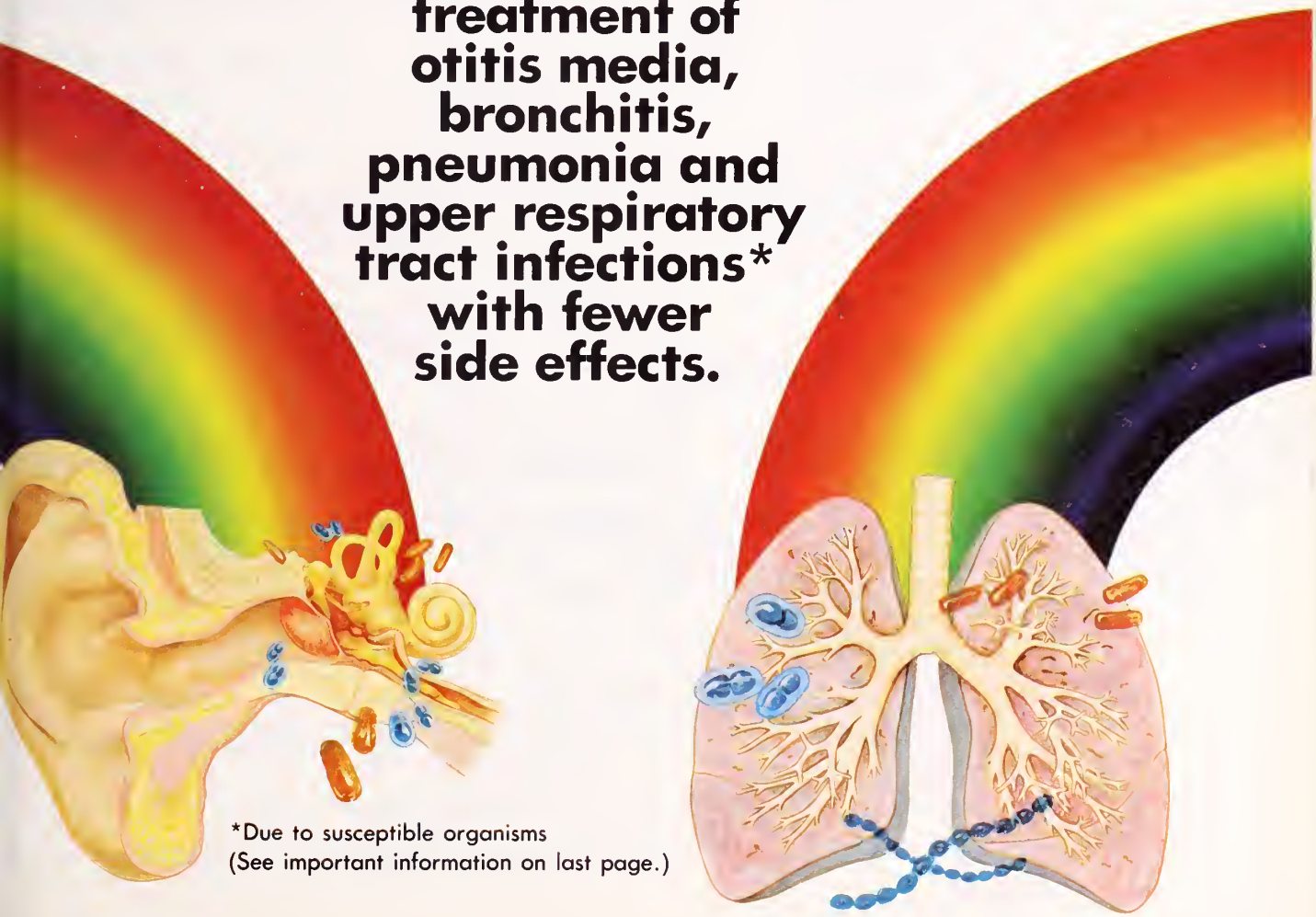
# more than just spectrum




# New CYCLAPEN®

## (cyclacillin) Tablets/ Suspension

**Efficacy proven in the treatment of otitis media, bronchitis, pneumonia and upper respiratory tract infections* with fewer side effects.**



*Due to susceptible organisms
(See important information on last page.)

# New CYCLAPEN®

## (cyclacillin) Tablets/ Suspension

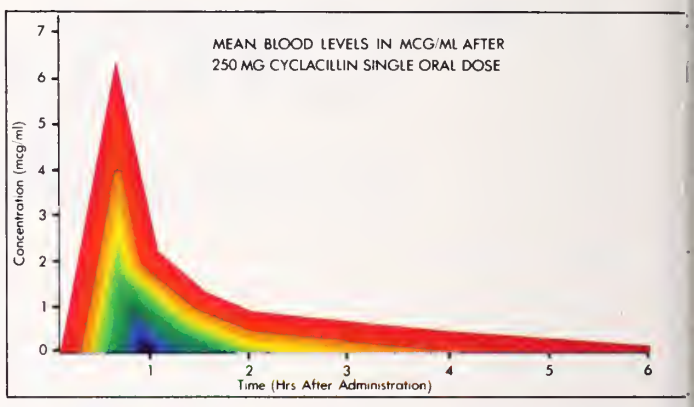
# efficacy with fewer side
# ampicillin confirmed in
# studies of 2,581

Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin

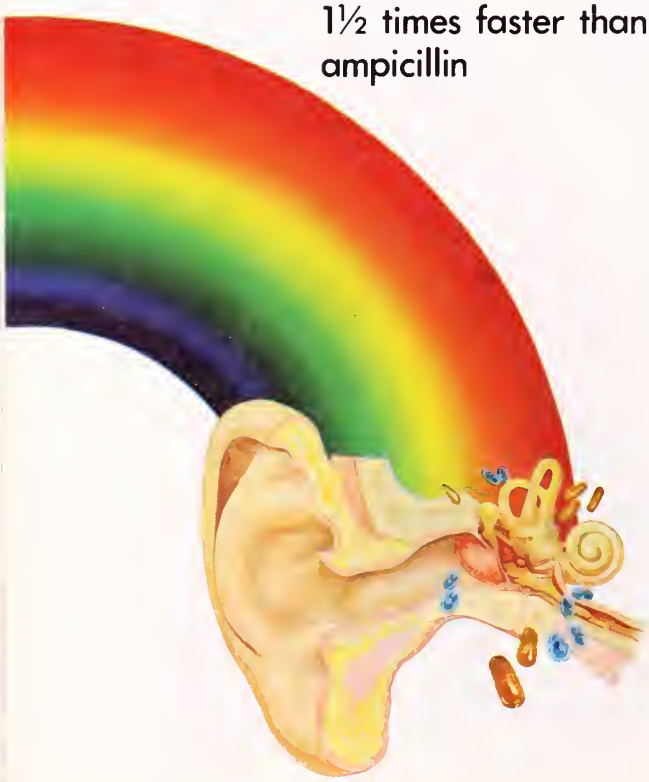



Clinical efficacy of CYCLAPEN® in otitis media†

| Causative Organism | | No. of Patients |
|---|---|---|
| *S. pneumoniae* | 96 | 82 |
| | 95 | |
| *H. influenzae* | 88 | 96 |
| | 85 | |

% Clinical Response
% Bacterial Eradication

## more than just spectrun
## in otitis media



*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

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# effects than double-blind patients*

Fewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

| Total number of drug-related side effects in all patients | |
|---|---|
| CYCLAPEN® | 128 of 1,286 (10%) of patients |
| ampicillin | 202 of 1,129 (18%) of patients |
| Difference statistically significant (P <0.001) | |

CYCLAPEN® (cyclacillin)
Effective for otitis media† in children

- Excellent clinical results in eliminating the two most common causative organisms in otitis media
- Significantly lower incidence of diarrhea and skin rash in children treated with CYCLAPEN® Suspension

| | diarrhea | rash |
|---|---|---|
| CYCLAPEN | 9.1% | 2.1% |
| ampicillin | 19.2% | 5.8% |
| | P < 0.001 | P < 0.03 |

## In bronchitis, pneumonia and upper respiratory tract infections†

| High cure rate with CYCLAPEN® | | |
|---|---|---|
| Causative Organism | Bronchitis/Pneumonia† | No. of Patients |
| *S. pneumaniae* | 100 | 73 |
| | 95 | |
| Chranic Bronchitis† (ocute exocerbation) | | |
| *H. influenzae* | 92 | 12 |
| | Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chranic respiratory disease due to *H. influenzae* | |
| Streptocaccal Sare Thraat† | | |
| Group A beta-hemolytic Streptococcus | 100 | 44 |
| | 86 | |
| % Clinical Response | | |
| % Bacterial Eradication | | |

# more than just spectrum CYCLAPEN®

(cyclacillin) Tablets/ Suspension


1. Gold JA, Hegarty CP, Deitch MW, Walker BR: Dauble-blind clinical trials of oral cyclacillin and ompicillin, *Antimicrob Ag Chemather 15*:55-58, (Jon.) 1979.
2. Dota on file, Wyeth Laboratories.


(See important information on next page.)

Wyeth Laboratories
Philadelphia, Pa 19101

New from Wyeth Laboratories

# CYCLAPEN®
## (cyclacillin) Tablets/ Suspension

Usual children's dosage: 50 to 100 mg/kg/day in equally spaced doses, depending on severity.

# more than just spectrum in otitis media, bronchitis, pneumonia, and upper respiratory tract infections*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

## How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

**Indications**

*Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.*

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

**Contraindications**

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

**Warnings**

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN. ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

**Precautions**

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

**Adverse Reactions**

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

**Dosage and Administration**

| INFECTION* | ADULTS | CHILDREN |
|---|---|---|
| | | Dosage should not result in a dose higher than that for adults. |
| *Respiratory Tract* | | |
| Tonsillitis & Pharyngitis** | 250 mg q.i.d. in equally spaced doses | body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses<br>body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses |
| Bronchitis and Pneumonia | | |
| Mild or Moderate Infections | 250 mg q.i.d. in equally spaced doses | 50 mg/kg/day q.i.d. in equally spaced doses |
| Chronic Infections | 500 mg q.i.d. in equally spaced doses | 100 mg/kg/day q.i.d. in equally spaced doses |
| *Otitis Media* | 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity | 50 to 100 mg/kg/day in equally spaced doses depending on severity |
| *Skin & Skin Structures* | 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity | 50 to 100 mg/kg/day in equally spaced doses depending on severity |
| *Urinary Tract* | 500 mg q.i.d. in equally spaced doses | 100 mg/kg/day in equally spaced doses. |

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

*Patients with Renal Failure*

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of > 10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

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# Quinamm™

**AVAILABLE ONLY ON PRESCRIPTION**

**Brief Summary**

**INDICATIONS:** For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities

**CONTRAINDICATIONS:** Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity and in patients with glucose-6-phosphate dehydrogenase deficiency Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine

**PRECAUTIONS:** Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients Recovery will follow withdrawal of the medication Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants

**ADVERSE REACTIONS:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued

**DOSAGE AND ADMINISTRATION:**
1 tablet upon retiring When necessary, 1 additional tablet may be taken following the evening meal

Product Information as of September, 1977

U.S. Patent 2,985,558

# Merrell

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

*Direct Medical Inquiries to*
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Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U S A

Licensor of Merrell™

# Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

## specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease . . . consider Quinamm . . . simple, convenient dosage—usually just one tablet at bedtime . . . can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.

Tagamet®
brand of
cimetidine
How Supplied:
Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).
Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.
SK&F LAB CO.
a SmithKline company
2 ml. = 300 mg.
Tagamet
(cimetidine HCl
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brand of cimetidine
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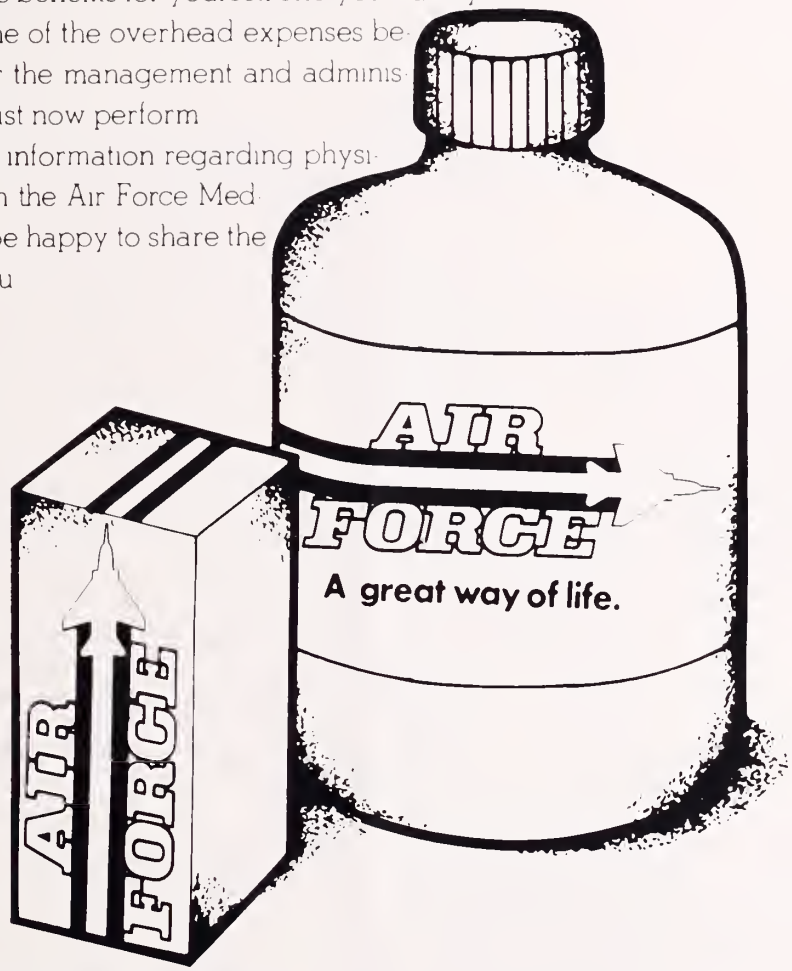


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125, 250, and 500 mg*
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125 and 250 mg*/5 ml

**V-Cillin K®**
**penicillin V potassium**

**Description:** V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

**Indications:** For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

**Contraindication:** Previous hypersensitivity to penicillin.

**Warnings:** Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

**Precautions:** Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

**Adverse Reactions:** Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

***Equivalent to penicillin V.**

*Additional information available to the profession on request.*

Lilly

Eli Lilly and Company
Indianapolis, Indiana 46206

900416

The West Virginia Medical Journal

Vol. 76, No. 3 March, 1980

# Ureterocutaneous Fistula Following Nephrectomy

JOHN A. BELIS, M. D.
*Assistant Professor of Urology, West Virginia University Medical Center, Morgantown*

BRADFORD M. McCUSKEY, M. D.
*Ohio Valley Medical Center, Wheeling, West Virginia; and Clinical Associate Professor of Urology, WVU Wheeling Division*

*Ureterocutaneous fistula after nephrectomy is a rare complication. A case is described in which this complication occurred in a patient with delayed hypersensitivity to chromic catgut suture.*

Development of a ureterocutaneous fistula following flank nephrectomy for chronic atrophic pyelonephritis is an unusual complication. This complication was observed more frequently in the past in association with nephrectomy for tuberculosis, and was probably caused by active tuberculosis in the ureter.[1,2] Other causes for persistent drainage of urine from the flank after nephrectomy include persistent renal tissue because of previous operations and fibrous perirenal scarring,[3] patent ureter with vesico-ureteral reflux,[3] and use of non-absorbable suture for ureteral ligation with subsequent wound infection and fistulization.[4] In the present case, ureterocutaneous fistula followed nephrectomy for chronic atrophic pyelonephritis with persistent urinary tract infection and was associated with a hypersensitivity reaction to catgut suture. Immediate and delayed allergic reactions to catgut have been reported previously with eye surgery,[5-7] and may have been related to development of ureterocutaneous fistula in the present case.

### Case Report

A 69-year-old white woman had her right kidney removed in 1971 for chronic atrophic pyelonephritis associated with pain and persistent urinary tract infection. Catgut suture was used throughout the surgical procedure. The immediate postoperative course was uneventful; however, a number of weeks after surgery the wound became indurated and subsequently developed multiple sinus tracts with small amounts of purulent drainage. A number of chromic catgut sutures extruded from the sinus tracts and were removed. Tuberculin skin test was negative, and the patient had no previous history of tuberculosis. Sinus tract formation and subsequent removal of non-absorbed catgut suture recurred over the next five years and was finally treated

**Figure. Sinogram demonstrating ureterocutaneous fistula.**

by total wound excision. Preoperative skin testing demonstrated delayed hypersensitivity to chromic catgut suture material. A single sinus tract with purulent drainage developed after surgery, and a sinogram demonstrated a ureterocutaneous fistula with possible ureteral calculus (Figure). Vesicoureteral reflux was suspected, but a voiding cystourethrogram was normal. Total right ureterectomy was performed and the wound closed with wire. No ureteral calculus was found. The patient has had no further difficulties one year after ureterectomy.

### Discussion

Ureterocutaneous fistula after flank nephrectomy has become very uncommon since the development of anti-tuberculosis drugs and the marked reduction in renal surgery for tuberulosis. The ureterocutaneous fistula which occurred in the present case, and which probably was present for six years, may have been related to the patient's hypersensitivity to catgut suture with recurrent sinus tract formation. Previous cases of allergy to catgut before 1950 were related to impurity in preparation,[8,9] but occasional cases have been described in the past 20 years in abdominal[10] and ophthalmologic surgery.[5-7]

The normal mechanisms for degradation of catgut in the genito-urinary tract have been described histologically and involve the formation of a bilaminar connective tissue capsule around the suture followed by gradual absorption of the implant by the inner layer of histiocytes, fibroblasts, lymphocytes, neutrophils and eosinophils.[11]

Actual degradation of catgut in guinea pig bladder was much slower than expected with 87 per cent of sutures remaining at 130 days after implantation.[11] Calculus formation was dependent upon protrusion of catgut into the bladder lumen. If sutures were tied in a normal manner, the luminal portions were rapidly covered by epithelium, and calculus formation did not occur. In contrast, calculi often formed on loops of catgut suture which protruded into the bladder lumen and could not be rapidly epithelialized.

Hypersensitivity reactions to catgut may be categorized into immediate and delayed tissue reactions.[6] Immediate reactions occur in the minority of cases and usually develop in patients who have had previous surgery. Delayed reactions occur in the majority of cases, and most patients in this group have not had previous surgery.[6] Suggested etiologies for these reactions include immediate and delayed hypersensitivity, mechanical irritation, and foreign body reaction,[7] but evidence appears to favor an immunologic reaction in most cases.[6] Comparison of other absorbable suture materials in the bladder demonstrated less inflammatory tissue reaction with polyglycolic acid and polyglactin-910.[12,13] However, a possible case of delayed hypersensitivity reaction to polyglactin-910 has recently been described.[7]

The possible contribution of allergenicity of absorbable suture material to delayed wound healing is unknown. Skin testing can be useful in the proper diagnosis of hypersensitivity to absorbable suture material and may best be used with patients who have postoperative wound complications that may be caused by this problem. If a patient has postoperative wound problems as described in the present case, and a diagnosis of allergic reaction to suture material can be made, total wound excision may be advisable. Steroid therapy may also be valuable when wound excision is not possible.[7]

### References


1. Lazarus JA: Prevention and treatment of delayed wound healing and ulcerative cystitis following surgery for tuberculosis of the genitourinary tract. *J Urol* 55:160, 1946.

2. Rolnick HC: *The Practice of Urology*, vol 1, Philadelphia, JB Lippincott Co, 1948, pp 796-797.

3. Winsbury-White HP: *Textbook of Genito-Urinary Surgery*, vol 1, Baltimore, Md, Williams and Wilkins Co, 1961, pp 364-366.

4. Williams G, Castro JE: A complication of nephrectomy by the supracostal approach. *Brit J Urol* 48:106, 1976.

5. Nay W: Catgut reactions in squint surgery. *Can J Ophthalmol* 1:283, 1966.

6. Apt L, Costenbader FD, Parks MM, Albert DG: Catgut allergy in eye muscle surgery. *Arch Ophthalmol* 63:30, 1960.

7. Martin-Casals A, Scott WE: Reaction to polyglactin 910 (vicryl): A case report. *J Ped Ophthalmol* 14:178, 1977.

8. Sewell WR, Wiland J, Craver BN: A new method of comparing sutures of ovine catgut with sutures of bovine catgut in three species. *Surg Gynecol & Obstet* 100:483, 1955.

9. Bartone FF, Shires TK: The reaction of the urinary tract to catgut and reconstituted collagen sutures. *J Urol* 101:411, 1969.

10. Sampsel JW: Delayed and recurring infection in postoperative abdominal wounds. *Am J Surg* 132:316, 1976.

11. Bartone FF, Shervey PD, Gardner PJ: Long-term tissue responses to catgut and collagen sutures. *Invest Urol* 13:390, 1976.

12. Case GD, Glenn JF, Postlethwait RW: Comparison of absorbable sutures in urinary bladder. *Urol* 7:165, 1976.

13. Milroy E: An experimental study of the calcification and absorption of polyglycolic acid and catgut sutures within the urinary tract. *Invest Urol* 14:141, 1976.

# Sports Medicine And The Adolescent Athlete

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*The benefits to be derived from a well-organized athletic program can not be overemphasized. The two main areas of concern when considering the adolescent athlete are protection of the growth plate and the psyche. Most physicians engaged in direct patient care will eventually be involved in problems relating to Athletic Medicine. We can expect to be faced with such problems with increasing frequency in the future. It is hoped that this discussion will be of benefit in understanding the relationship of Athletic Medicine to our present day adolescent athlete.*

THERE is an ever-increasing worldwide interest in athletic participation among all age groups. Nowhere is this more in evidence than in the adolescent years. Not infrequently, individuals attain world-class competitive status while still in their teens. In recent years, this has been noted in swimming, track, gymnastics, skiing, ice-skating, and tennis. It should be noted that these are basically individual rather than team events emphasizing speed, endurance and coordination rather than size and strength. Obviously, these athletes were hard at work during their early adolescent years perfecting skills, developing strength, endurance and speed, and hopefully learning to cope with victory and defeat.

More often than not, it is during the adolescent years that the decision is made regarding how seriously an athletic endeavor is to be pursued. Those who continue seriously are usually channeled into an organized program. Such programs should offer some form of medical supervision, provide adequate facilities and equipment, good coaching, an outlined conditioning program, and various levels of competition.

It is important to understand how the adolescent is endowed anatomically, physiologically and emotionally for athletic competition.

At the outset of the adolescent period male and female body size is comparable. Males have achieved approximately 80 per cent of their ultimate height and 55 per cent of their weight; females, approximately 85 per cent of their height and 60 per cent of their weight. Therefore, non-skeletal growth increments are of greater magnitude than skeletal growth during adolescence.

In childhood, muscle contributes roughly 25 per cent of the total body weight; by maturity it is 50 per cent, constituting somewhat more of the total body weight in males than in females. Males achieve a larger, leaner body mass with heavier skeletal and muscle components and less body fat than females. Both muscle cell numbers and size increase in the adolescent male; while in the female, muscle cell size rather than number increases. In males, muscle cell numbers double between the ages of 10 and one half and 16.

### Activation of Gonads

The most striking endocrine event during adolescence is activation of the gonads with secretion of large amounts of estrogen in the female and androgen in the male. During this period rapid growth is experienced. The structure of the epiphyseal plate varies according to relative levels of growth and sex hormones. Growth hormone directly stimulates proliferation of epiphyseal cartilage cells which thus increases in thickness. This results in a significant decrease in the shearing strength of this structure. Estrogen and testosterone act directly to suppress this proliferation, decreasing the thickness of the epiphyseal plate but increasing its ability to resist stress.

In childhood, the periosteum is thick and spans the epiphyseal plate area. During adolescence, the periosteum undergoes some degree of atrophy, thins, and contributes to the weakness of the plate. Tendons may be stronger than the bony apophysis and, with stress, the apophysis may be avulsed rather than the tendon being torn.

Physiologically, the overall effect of changes during adolescence is to increase greatly the strength of the individual and his capacity for physical exertion. The heart rapidly increases in size, and the heart rate gradually lessens. Adult-level blood pressure is reached. In males, the number of red blood cells increases markedly; therefore, the oxygen-carrying capacity likewise increases.

### Respiratory Rate Decreases

The respiratory rate decreases, but the maximum amount of air which can be breathed in at a given time or in a single breath increases.

The amount of air which must be inhaled in order to pass a given amount of oxygen into the blood, and therefore to muscle, becomes less. The cardio-respiratory system becomes much more efficient during adolescence.

The oxygen debt mechanism allowing muscle to function anaerobically increases in efficiency at puberty and continues to improve until the late teens. As a result of all these changes more oxygen can be made available to the exercising muscle, while the muscles themselves become capable of greater activity. The total capacity for physical work is thus increased enormously in both males and females during adolescence.

Improvement in neuromuscular coordination occurs simultaneously with the increase in muscle strength. Reaction time decreases markedly between the ages of 14 and 18.

Therefore, the amalgamation of skeletal growth, muscle growth, increasing muscle strength, improved coordination, and cardio-respiratory efficiency results in the potential for superior athletic ability during adolescence.

The mental outlook is of paramount importance. Above all, the individual should be self-motivated rather than succumbing to parental or other outside pressures to excel athletically. Emotionally, adolescence is characterized by an increasing conflict with oneself and the outside world. There is a tremendous amount of physical, emotional and sexual energy, all of which can surface and be released quite aggressively in various directions. It would seem most healthy to divert such energies toward some athletic endeavor.

It is important to understand what is required physically of the adolescent athlete and determine how such demands affect him.

#### Lower Extremities' Effects

The adolescent is well-adapted for either speed or endurance running. If the initial physical examination is normal, and proper training schedules have been followed, endurance and speed events may be safely pursued. Many sprinters have achieved world-class times while in their teens. The United States age group records for the marathon exemplify the adolescent's adaptability for endurance events. The record for 12-year-old males is two hours, 54 minutes and 34 seconds, which is an average of 6.7 minutes per mile; for females, three hours, three minutes and 32 seconds, or approximately seven minutes per mile. The records for males and females from age 12 to 17 show progressively faster times with the improvement being more marked in the male's performance.

Speed and endurance running may produce in the adolescent the same problems as in any other age group. The most common are those secondary to overuse such as tendinitis, shin splints, compartment syndromes, fasciitis, stress fractures, and muscle strain. Many pre-existing orthopedic conditions may be aggravated by either speed or endurance running. Most of these involve the lower extremities. Examples are osteochondritis dissecans, Osgood-Schlatter disease, chondromalacia patella, and mechanical foot problems.

#### Upper Extremities' Stresses

Abuse of the immature upper extremities from throwing may result in significant residual disability throughout life. Such abuse was not uncommon in the past before rules and regulations were created to protect the young athlete in this regard. Most of the damage resulted from either excessive traction or compression of growth plates not yet closed, the elbow being most vulnerable.

Some of the resulting lesions frequently progress to traumatic arthritis with permanent impairment of joint function. Other lesions are completely reversible, resulting in an eventual return to a normally-functioning joint.

Baseball pitching is the big offender, and if one understands the mechanism of this action he can more readily understand the pathology which may result. The goal of the pitcher is to produce a rhythmic sequence of forces building up to a maximum velocity at the proper release angle with as much accuracy as possible. The force and torque exerted on the extremity may be tremendous.

The shoulder enters the rhythm of pitching first with the arm in extreme external rotation, abduction and extension. The strong, internal rotators and adductors then bring the arm down and forward into internal rotation with great force. This places extreme force on the proximal humeral epiphysis, and repeated pitching may result in fragmentation, demineralization and widening of this proximal epiphysis. With cessation of pitching, these changes are reversed and no serious residual is noted. After symptoms have subsided and x-rays reverted to normal, pitching may be resumed safely.

The situation in the elbow is somewhat different. With cocking and delivery the elbow goes into extreme valgus and flexion with traction on the medial structures, especially the medial epi-

condyle, the flexor-pronator muscle mass and the ulnar nerve. Repeated pitching may result in fragmentation and eventual hypertrophy of the medial epicondyle. A single, forceful pitch can result in avulsion of this structure. With cessation of pitching, these changes are reversible. When the extremity is asymptomatic and x-rays are again normal, pitching may be resumed safely.

On the radial side, the cocking and delivery motion results in marked compression. Repeated, hard throwing may result in osteochondritis of the radial head and capitellum, loose bodies, and deformity of the bony structures. Ultimate degenerative arthritic change may result. These changes are not reversible and can lead to marked, permanent impairment. Any player developing x-ray changes in the lateral compartment of the elbow should be permanently excluded from pitching.

### Lifting

In addition to running and throwing the athlete is also engaged in lifting. This function, technically speaking, is part of all sporting events. Athletes lift an almost innumerable number of various-sized and shaped objects for an almost equally innumerable number of reasons. They not only lift their own bodies, but in many sports are expected to lift the body of an opponent.

Generally, lifting in athletics is thought of in terms of weight training, or lifting relatively light weights through numerous repetitions to develop strength and endurance. Most athletes now follow such a weight training program, the design of which is greatly influenced by the sport in which the individual participates. Such programs generally emphasize isotonic techniques, though the benefits of isokinetic training are becoming more widely acclaimed. Most young athletes can engage safely in these programs, achieving the desired result without endangering anatomic structures.

Weight lifting for competitive purposes is a sport in itself in which athletes strive to lift a maximum weight. This is quite a different matter for the adolescent athlete and should be avoided until skeletal maturity is attained. Improper or excessive lifting may result in serious damage to the musculoskeletal and cardiovascular systems.

Attempts at lifting excessive amounts have resulted in upper-extremity fractures, especially of the distal radial epiphysis and in muscle and tendon tears and avulsion of traction apophyses. Another potentially serious consequence of improper technique in bulk lifting is the production of the Valsalva maneuver. The novice invariably will inhale before the power lift, forcing the inhaled air against the closed glottis, with the consequences of sudden rise in blood pressure, decreased venous return, increased heart rate and decreased output.

Bulk lifting is clearly contraindicated in the presence of such conditions as unstable weight-bearing joint, mechanical low back problems such as spondylolisthesis, Scherrmans epiphysitis, inguinal hernia, and pre-existing hypertension, to name a few.

### Jumping

The action of jumping is necessary in many athletic events. Repetitive jumping may result in a number of over-use syndromes such as "jumper's knee," which actually is a tendinitis involving both the inferior portion of the quadriceps tendon and the patellar tendon. Repetitive jumping also may aggravate markedly pre-existing chondromalacia patella or Osgood-Schlatter disease.

### Summary

The number of adolescents participating in athletics is undeniably on the rise. The degree of involvement varies from the casual participant to the world-class athlete. The anatomic and physiologic changes which occur during this period of development make them tremendously well-adapted for athletics. If there are no physical contraindications, athletic goals may be vigorously pursued. Using proper technique and following a well-outlined training schedule, nothing more than the common problems occurring in adult-age athletes is to be anticipated.

The basic mechanics of athletic competition as related to the adolescent have been reviewed. Assuming that no physical contraindications exist, speed, middle distance and marathon running can be engaged in without restriction, as can jumping events. There are definite and specific restrictions in throwing events, especially baseball pitching, where the immature elbow can be irreparably damaged. As regards lifting, there are no restrictions to a proper weight-training program; however, competitive, maximum weight lifting should be avoided until epiphyses are closed.

# Medical Grand Rounds

**From the West Virginia University Medical Center**

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## Mononucleosis Syndromes

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*A mononucleosis syndrome is defined as fever, lymphocytosis and the presence of at least 10 per cent atypical lymphocytes in the blood. Epstein-Barr virus (EBV), cytomegalovirus (CMV), Toxoplasma gondii and perhaps adenovirus are causative agents. Clinical features and diagnostic approaches are examined. EBV- and CMV-induced mononucleosis are discussed as examples of infections due to the herpes group of viruses, correlating virus-cell interactions with cellular and humoral immune responses.*

INFECTIOUS mononucleosis is a common disease among young adults, with an annual incidence of 13 per cent among seronegative persons 18 to 22 years old. In addition to Epstein-Barr virus (EBV), which causes infectious mononucleosis, a mononucleosis syndrome may be caused by several other agents, listed in Table 1. A mononucleosis syndrome is defined by the constellation of fever and lymphocytosis of 50 per cent or more with atypical lymphocytes comprising at least 10 per cent of total leukocytes.

This review will examine some clinical features and differential diagnoses of mononucleosis syndromes. It will also use infectious mononucleosis and cytomegalovirus mononucleosis to illustrate typical features of herpes group virus infection, and emphasize host-virus interactions. Finally, specific serodiagnosis and complications of EBV infections will be discussed in terms of host-virus interactions.

### Toxoplasmosis

Toxoplasmosis, due to Toxoplasma gondii, accounts for an occasional case of the mononucleosis syndrome.[1] The parasite is ingested, usually contained in under-cooked meat or kitten feces. Following penetration of the gastrointestinal mucosa, the organism disseminates widely to locations including lung, eye, central nervous system, liver, spleen, lymph nodes, and the musculoskeletal system.

Most often, the disease presents with fever, adenopathy and signs of involvement of an affected organ or organs. Of patients with the mononucleosis syndrome, 20 per cent have pharyngitis. Adenopathy is often generalized and fever may persist for weeks.

Diagnosis may be made by demonstrating characteristic histopathologic changes, culture of the parasite from lymph node biopsy, or by a rising or falling antibody titer detected by Sabin-Feldman dye test, indirect hemagglutination or indirect immunofluorescence. Except in the immunocompromised host, therapy is supportive, and the disease resolves over several months, usually with no sequelae.

### Adenovirus

The role of adenovirus in causing the mononucleosis syndrome remains obscure. This virus is a familiar cause of nonspecific upper respiratory disease in young adults which is often accompanied by pharyngitis, conjunctivitis, and regional adenopathy.

In a series of cases of heterophile negative mononucleosis by Wahren,[2] 11 per cent of cases had at least a four-fold antibody rise to adenovirus, but the author discounted the agent as a likely cause. In other series, occasional antibody rises in response to this virus have also been documented. Diagnosis may be made by demonstration of a four-fold rise in complement fixing antibody to adenovirus, or by virus isolation from the nasopharynx.

Treatment is supportive.

### Epstein-Barr Virus

Approximately 90-95 per cent of mononucleosis syndromes are caused by EBV. These are known specifically as "infectious mononucleosis." Although unusual manifestations or severe complications tend to be reported, nearly 90 per cent of cases present with a typical clinical illness.[3] Table 2 shows these usual features, comprising a triad of clinical, hematologic and serologic findings, Fever, fatigue, pharyngitis and lymphadenopathy (particularly with anterior and posterior cervical lymph node involvement) each occurs in 80-90 per cent of cases. Pharyngeal or tonsillar exudate occurs in one third of cases. As Evans described it,[4] "Two types of exudate were commonly seen: one was whitish, rather discrete, and pasty, and appeared superficially over the tonsils and in the crypts somewhat like an old cake in which most of the frosting has hardened and fallen off; the other was greenish-gray, adherent, and spread confluently over the tonsil, leaving a bleeding, ulcerated area in its wake as it sloughed."

**TABLE 1**
**Infectious Agents Causing the Mononucleosis Syndrome**

| |
|---|
| Epstein-Barr virus |
| Cytomegalovirus |
| Toxoplasma gondii |
| Adenovirus (?) |

**TABLE 2**
**Typical Findings in Infectious Mononucleosis**

| |
|---|
| *Clinical findings:* |
| Common |
| Fatigue and malaise |
| Fever |
| Adenopathy (posterior and anterior cervical) |
| Splenomegaly (50%) |
| Palatal enanthem (30%) |
| Periorbital edema (10-20%) |
| Uncommon |
| Hepatomegaly (10%) |
| Rash (5% or less) |
| Jaundice |
| Hematologic abnormalities |
| Lymphocytosis (>50%) |
| Atypical lymphocytosis (>10% of leukocytes) |
| Mild thrombocytopenia—common |
| Serological |
| Positive heterophile antibody |

An enanthem, consisting of petechiae at the junction of hard and soft palate, is seen in one third to two thirds of cases. In half of patients, splenomegaly is present. Hepatomegaly occurs in 10 per cent. Although jaundice is rare, hepatitis, manifested by abnormal liver enzymes, is almost universally present.

### Diagnostic Tests

Heterophile antibody agglutinates the red blood cells of sheep and other hoofed animals, but does not agglutinate guinea pig kidney cells. Tests such as the Monospot®, Mono-Test® and Mono-Diff® use a slide modification of the heterophile with horse red blood cells. A positive test can be expected in two thirds of cases in the first week of illness, 80 per cent by the third week and 90 per cent or more by four to six weeks. Thereafter, the titer usually declines rapidly, but occasionally may persist for a year or more.

More than 90 per cent of cases of infectious mononucleosis pursue an uncomplicated course with recovery in a few weeks. Fatigue for over a month, however, is not uncommon, and rare relapses or cases with prolonged illness have been reported.

### Cytomegalovirus

Table 3 compares mononucleosis due to cytomegatovirus (CMV) and EBV. In CMV mononucleosis a slightly older population is usual, and pharyngitis, splenomegaly and adenopathy are not characteristic.[5] Fever, however, may be prolonged for up to six weeks. Diagnosis is made by finding a negative heterophile test, and by demonstration of a rise in complement fixing antibody to CMV with or without culture of the virus. As with EBV, CMV disease is generally self-limited.

### Herpes Group Infections

Mononucleosis due to either EBV or CMV is representative of infection due to members of the herpes group of viruses, shown in Table 4. These DNA viruses are most notable clinically for their latency with a penchant for later reactivation. Morever, disease acquired earlier in life is usually relatively mild compared to that acquired later. Thus, chickenpox is usually mild in childhood, but a serious illness in adults. Simi-

**TABLE 3**
**Mononucleosis Syndromes Caused by EBV and CMV**

| | *EBV* | *CMV* |
|---|---|---|
| Age | 15-25 | over 25 |
| Fever | 1-2 weeks or more | more than 2 weeks |
| Pharyngitis | usually exudative | uncommon |
| Adenopathy | anterior and posterior cervical | uncommon |
| Splenomegaly | present in 50% | uncommon |
| Serology | | |
| heterophile antibody | positive in 90% | negative |
| EBV-VCA antibody | positive in 100% | may be positive |
| CMV CF antibody | negative or stable | rising titer |

larly, most herpes simplex is acquired asymptomatically in childhood. An acute febrile illness, gingivostomatitis, may, however, appear in the younger group. Young adults who first encounter herpes virus via genital infection often have marked local symptoms with fever and prolonged course. CMV and EBV otherwise are usually asymptomatic during childhood, but often manifest themselves as mononucleosis or other illness when acquired in adolescence or in young adulthood.

All of these agents remain latent in cells for the life of the infected host. Under certain conditions, often associated with immunosuppression, reactivation may occur. Overt disease associated with reactivation is variable. Thus, herpes zoster due to reactivation of varicella-zoster virus and recurrent herpes genitalis due to reactivation of herpes simplex virus are well recognized. CMV may be reactivated to cause a mononucleosis syndrome or interstitial pneumonia in patients who are immunosuppressed due to treatment of malignancy or for transplantation. EBV may rarely reactivate clinically with recurrence of mononucleosis. More commonly, increased activity of EBV is limited to enhanced salivary excretion of virus in immunosuppressed subjects.

### EBV Infection

Let us now examine cellular infection by EBV, emphasizing those events which produce diagnostically-useful changes in the infected cells.[6] After penetration of its target, the B lymphocyte, virus DNA is encoded into the cell genome. Other copies remain free in the cytoplasm. Cells infected with EBV express two antigens, LYDMA (lymphocyte detected membrane antigen) and EBNA (Epstein-Barr nuclear antigen), whether or not further virus synthesis occurs. Cells thus infected are immortalized, divide actively and survive for long periods in tissue culture. With certain cell lines and various environmental manipulations, cells may enter a lytic phase, eventuating in virus production. Early in this sequence, EA (early antigen) is produced. This antigen probably reflects a virus-coded inhibitor of cell DNA synthesis. Cells expressing it eventually die. If virus production is completed, VCA (virus capsid antigen) is observed. The cell dies at the time of or shortly after expression of VCA. It should be noted that antibody production to these antigens occurs in approximately reverse order, due to host defense interactions which we will discuss now.

**TABLE 4**
**Herpes Group Viruses**

| |
|---|
| Cytomegalovirus |
| Epstein-Barr virus |
| Varicella-zoster virus |
| Herpes simplex virus |

### Immunologic Changes

In herpes group virus diseases in general, humoral immunity may be important in preventing exogenous reinfection, but probably plays little role in limiting virus reactivation. Cellular immune defenses, however, are of major significance. Work done in transplant patients and asymptomatic CMV-excreting infants supports this concept.[7,8] Despite high antibody titers to CMV, virus excretion develops in these latently infected individuals. Spontaneous lymphocyte blastogenesis is increased; blastogenesis in response to mitogens is relatively intact. Lymphocyte blastogenesis in response to CMV-specific antigens, however, is markedly depressed. Thus, reactivation of latent CMV infection is associated with impaired cellular immune response to the virus, but intact humoral responses.

Observations as host defenses develop in acute primary EBV infection (infectious mononucleosis) reflect similar control mechanisms. These are shown in Table 5. Thus, in acute diseases, cellular immunity in general, including skin test reactivity, is depressed.[9] EBV-specific cellular immune responses, however, are intact or enhanced.[10]

Cytotoxic T cells directed against EBV-infected B cells are present, as are cells capable of suppressing antibody formation.[11] The cytotoxic cells persist during convalescence but suppressor cells decline. Using these concepts and those of virus-cell interaction, let us now consider what happens in acute infectious mononucleosis.

### Correlation With Clinical Findings

During the prodromal stages of fatigue and weakness, before acute illness, infected B cells proliferate wildly, resembling what Dameshek has called a self-limited neoplasm.[12] During this time, a number of non-EBV-related antibodies are produced by infected B cells. Some, like the heterophile, anti-i (red blood cell antigen), anti-granulocyte or anti-platelet antibodies, are of diagnostic or pathogenetic significance. Others, such as anti-nuclear antibody, rheumatoid factor, reaginic antibody (causing a false-positive VDRL) cold agglutinins, and anti-smooth muscle antibody, are not.

VCA is expressed as virus is produced, with a resultant rise in IgG and IgM antibodies. IgM falls over the next several weeks, but IgG persists for life. Similarly, expression of EA accompanies virus production and results in antibody formation. With development of the cellular immune response, infected B cells are destroyed. This interaction may be reflected by the clinical signs and symptoms of inflammation with atypical lymphocytes in the blood. Production of antibody to EBNA, however, is delayed, perhaps due to suppressor cell effects, which may also turn off non-EBV antibody production. With the decline of suppressor lymphocytes, but persistent occasional lytic cycles by infected cells, anti-EBNA rises and IgG-VCA antibody persists for life.

**TABLE 5**
**Cellular Immunity in EBV-IM**

| | |
|---|---|
| I. | Acute Disease |
| | Decreased Lymphocyte Blastogenesis to Mitogens and Antigens |
| | Impaired Delayed Hypersensitivity |
| | Enhanced Suppressor Cell Activity |
| | Intact Blastogenesis in Response to EBV Infected Cells |
| II. | Convalescence |
| | Enhanced MIF Production and Blastogenesis in Response to EBV-Specific Antigen |

### Diagnosis of Mononucleosis

With these concepts in mind, an approach to the diagnosis of mononucleosis can be formulated. The choice of which tests to order and how extensive a workup is necessary must be guided by clinical findings and the need for a specific diagnosis. In early acute illness, a test for heterophile antibody or its equivalent may be done, with repeated tests every week for three to four weeks. If the heterophile is negative on first test, serum may be saved for other tests later. If the heterophile is persistently negative, acute and convalescent sera may be submitted for EBV-specific tests and CMV, toxoplasma and adenovirus titers.

Finding a positive IgM-VCA antibody or antibody to EA confirms the presence of active EBV infection. The combination of a positive IgG-VCA and negative anti-EBNA antibody is also compatible with acute EBV disease, and may be valuable if the first specimen is obtained several weeks after onset of clinical illness.

Clearly, attempts to document the etiologic agent of an acute, uncomplicated mononucleosis syndrome may in practice be limited justifiably to serial heterophile tests. Occasionally, however, complications of infectious mononucleosis occur (Table 6). These may also present in the absence of a mononucleosis syndrome, with a negative heterophile test. EBV-specific antibody tests may then be required for diagnosis. The patient may thus be saved more extensive diagnostic procedures. Moreover, most of the com-

**TABLE 6**
**Complications of Infectious Mononucleosis**

| | |
|---|---|
| *Hematologic* | |
| | Hemolytic anemia |
| | Granulocytopenia |
| | Thrombocytopenia |
| *Neurologic* | |
| | Aseptic meningitis |
| | Meningoencephalitis |
| | Guillain-Barre syndrome |
| | Peripheral neuropathy |
| | Facial palsy |
| | Transverse myelitis |
| *Miscellaneous* | |
| | Splenic rupture |
| | Pneumonitis |
| | Myocarditis |
| | Nephritis (mostly interstitial) |
| | Fulminant hepatitis |

plications, if due to EBV, are self-limited with a relatively good prognosis.

### Treatment

In general, treatment of infectious mononucleosis is supportive. Marked physical exertion should be avoided in the first three weeks to minimize the risk of splenic rupture. Otherwise, activity should be tailored to the individual's tolerance. Steroids may be indicated for impending respiratory obstruction due to enlarged tonsils, for hemolytic anemia, and for thrombocytopenia. Unknown as yet are long-term effects of the use of steroids in acute disease, particularly with regard to later development of malignancies. In view of the latency of EBV, the importance of cellular immunity in its control, and its clear association with two human malignancies (Burkitt's lymphoma and nasopharyngeal carcinoma), however, the therapeutic use of agents such as corticosteroids, which suppress cellular immune responses, probably should be sparing and judicious.

Recovery from all forms of the mononucleosis syndrome is nearly always complete, but the task of discovering the etiologic agent in some cases remains a satisfying diagnostic challenge to the clinician.

### References


1. Horwitz CA, Henle W *et al.*: Heterophil—negative infectious mononucleosis and mononucleosis-like illness. Laboratory confirmation of 43 cases. *Am J Med* 63:947, 1977.

2. Wahren B, Espmark A, Wallden G: Serologic studies on cytomegalovirus in relation to infectious mononucleosis and similar conditions. *Scand J Infect Dis* 1:145, 1969.

3. Karzon DT: Infectious mononucleosis. *Adv Pediatr* 22:231, 1976.

4. Evans AS: Infectious mononucleosis in University of Wisconsin students. Report of a five-year investigation. *Am J Hyg* 71: 342, 1960.

5. Klemola E, Von Essen R, Henle G *et al.*: Infectious mononucleosis-like disease with negative heterophil agglutination test. Clinical features in relation to Epstein-Barr virus and cytomegalovirus antibodies. *J Inf Dis* 121: 608, 1970.

6. Epstein MA, Achong BG: Recent progress in Epstein-Barr virus research. *Ann Rev Microbiol* 31: 421, 1977.

7. Gehrz RC, Knorr SO, Macker SC *et al.*: Specific cell-mediated immune defect in active cytomegalovirus infection of young children and their mothers. *Lancet* 1:844, 1977.

8. Pollard RB, Rand KH, Arvin AM *et al.*: Cell-mediated immunity to cytomegalovirus infection in normal subjects and cardiac transplant patients. *J Inf Dis* 137: 541, 1978.

9. Mangi RJ, Niederman JC, Kelleher JE *et al.*: Depression of cell-mediated immunity during acute infectious mononucleosis. *N Engl J Med* 291: 1149, 1974.

10. Nikoshelainen J, Ablashi DV, Isenberg RA *et al.*: Cellular immunity in infectious mononucleosis. II. Specific reactivity to Epstein-Barr virus antigens and correlation with clinical and hematologic parameters. *J Immunol* 121: 1239, 1978.

11. Tosato G, Magrath I, Koski I *et al.*: Activation of suppressor T cells during Epstein-Barr-virus-induced infectious mononucleosis. *N Engl J Med* 301: 1133, 1979.

12. Dameshek W, Gump F: *Leukemia*, New York, Grune and Stratton, 1964, p 566.

# Special Article

# The Human Factor*

CHARLES A. HOFFMAN, M. D.
*Huntington, West Virginia, Past President, West Virginia State and American Medical Associations, American Urological Association and United States Section, International College of Surgeons*

The original charge given to me was the subject of "Interdisciplinary Surgery—The Human Factor." Later, your chairman shortened the subject to "The Human Factor."

It would appear, however, that both portions of this are so closely related that they should be considered as one.

Webster defines interdisciplinary as " . . . involving two or more academic disciplines." In this case, it must be considered as involving inter-physician relationship.

The human factor must be considered to encompass not only the previously mentioned definition, but, also, the human factor which is always involved in the doctor-patient relationship.

There is no doubt that there has been a lessening of communications between the patient and his physician. This is understandable, for we are living in a world of ever-changing values.

One might ask, "If our world is changing, why is not the human factor improving rather than diminishing?"

It seems to me that there are many factors involved in this abridgment of trust and confidence between the physician and his patient.

### Factor in Increase of Claims

As one who had been active in the field of professional liability as a member of the President's Commission on Malpractice and Chairman of the American Medical Association's Committee on Malpractice, I came to the conclusion that this lack of confidence is a definite factor in the tremendous increase in malpractice claims against the physician.

A few years ago, Chesterfield Smith, then President of the American Bar Association, stated that the chief reason for our professional liability dilemma is that our society has become accustomed to receiving something for nothing and people are looking for any opportunity for redress regardless of who is responsible in a case of poor medical results.

I concur with his opinion.

Of less importance are the activities of the plaintiff bar and our legislative climate, and, lastly, but still an important factor, a diminishing doctor-patient relationship.

Our President's Commission on Malpractice held hearings in seven different cities throughout the country. One of the main incentives for filing a suit against a physician by a patient or a member of the family was not being able to get in touch with the physician after surgery, particularly if complications developed.

### A Troublesome Trend

The unlisted residence telephone numbers of the young physicians and the listed numbers of the older physicians suggest a troublesome trend is occurring.

Many physicians leave everything to the "little girl in the front office," who is often not sufficiently trained or may just lack interest.

Many physicians will take offense at the last statement, but, I doubt very much if any in this room will deny the fact that our public relations climate is deteriorating.

Those surgeons who are in the older age group recall how they received bare sustenance during their training period. They went through several years of struggling to develop a practice with sufficient income to live and pay their office expenses.

Today, the young surgeon is given a comfortable stipend during his internship and residency and, upon graduation, seeks income comparable to the surgeon who has been practicing 10-15 years.

As a member of the West Virginia Medical Licensing Board, it is interesting to note that many of the American physicians who are applying for reciprocity appear before the board dressed as if they were going for a tramp in the woods.

It is a far cry from my first year in medical school when Martin Fisher, Professor of Physiology, looked us over during our first day in class and openly criticized any student who was not dressed correctly with tie and coat, concluding his examination by saying, "You expect to be doctors. Dress and act like one; do not return to this class unless you are dressed correctly."

*Presented during the October 22, 1979, "Chaplain's Corner," Annual Meeting, American College of Surgeons in Chicago, Illinois.

Perhaps we should return to this disclipne.

An individual who seeks respect is much more likely to receive that respect if he is dressed appropriately.

Adversity breeds strength and compassion. May I repeat . . . adversity breeds strength and compassion. We are not seeing adversity among our young physicians who are starting practice today.

### How Physicians Are Trained

Although Blue Shield, third-party payors and government programs have been tremendous factors in changing our economic values, which in turn alter the doctor-patient relationship, one must also consider our methods of training physicians.

It would appear that many young physicians today have the attitude that. "I'll get mine quickly, in any manner I can."

Speaking in Washington. D. C., this year to a combined meeting of the Council on Medical Education of the American Medical Association and the Federation of State Medical Boards. Dr. Lewis Thomas, President of the Memorial Sloan-Kettering Cancer Center, said. in essence, "The very nature of our education is a factor in the lessening of human relations between the physician and his patient." He pointed out that medical school applicants, in most instances, are accepted by their scholastic standings only.

Doctor Thomas stated, "As they see it, anything that can be done to make sure of those straight As—even including acts of war that may result in the classmate at the next chemistry bench failing to achieve his own straight A, and thus falling out of the competition—is fair game.

Thus, the sabotaged experiments; the textbooks vanishing from the library's reserved shelves; the pages torn out of monographs and journals, and the long lines of aggrieved students at the door of any professor who has given a weekly test and marked it with a B.

### Attitude Continues

The attitude of these malfeasors carries on this effect into residency training and it continues to be more noticeable in the treatment of residents' patients during their early, active practice.

I mention "early" for it is the rare individual who does not become more compassionate as the number of his gray hairs increase.

Doctor Thomas advocated that our entire curriculum in our colleges and universities should be changed. Every student, whether he or she be pre-medical, pre-dental, pre-engineering or pre-law, should take the same course of studies. He stated, "Emphasis should be placed on the humanities. The curriculum should include Greek. Latin, philosophy, history, religion and linguistics."

"They (the students) also know, or at least think they know, that if they major in the classics or philosophy or linguistics or religion or English, or whatever other eccentricity—any major but science—they will be hindered as applicants. or even damaged."

### Teachers' Views Are Best

Doctor Thomas noted that the teachers in the graduate schools, having worked with the students for four years, were better able to determine just which profession the student was best equipped to pursue. The opinion of the undergraduate faculty should be considered in the acceptance of students for postgraduate studies.

Doctor Thomas continued, "The faculties of the postgraduate schools would once again be facing classrooms of students who are ready to be startled and excited by a totally new and unfamiliar body of knowledge—students who are eager to learn, unpreoccupied by the notions of relevance that are paralyzing the minds of first-year medical students, already so surfeited by science that they want to start practicing psychiatry in the first trimester of the first year."

"Society would be the ultimate beneficiary. We could look forward to a generation of doctors who have learned as much as anyone can learn, in our colleges and universities, about how human beings have always lived out their lives. Over the bedrock of knowledge about our civilization, the medical schools could then construct as solid a structure of medical science as can be built, but the bedrock would always be there, holding everything else upright," Doctor Thomas continued.

He then concluded by saying, "Technology does not breed compassion." This statement came from a technologist. I, personally, support this new concept in education. Doctor Thomas has expressed my feelings, beautifully.

In recent years, several deans of medical schools have told me that they know the best students, scholastically, do not necessarily make the best physicians. In fact, students with B averages often make the best physicians, but deans point out that they know of no other way to choose their applicants.

A member of the Admissions Committee of Georgetown University Medical School pointed

out that there have been far fewer drop-outs since a psychologist has been added to the selection committee.

### Need For More Physicians

During the latter part of the 1960s, President Johnson, in addressing the news media, stated that there was a tremendous shortage of physicians in this country, and that we should have 50,000 more physicians within the next few years. The conservative members of the Board of Trustees of the American Medical Association did not accept this claim literally.

The AMA did, however, make every effort within its power to increase the enrollment of our medical schools and to upgrade the few two-year schools which were in existence. The liberal segment of our society openly accepted the President's statement, and several schools began to offer a combined five-year course in medicine and pre-medicine.

A few of our state legislatures passed statutes allowing state medical boards to offer licensure to applicants who had only five years of graduate study.

Along with this came a heavy influx of foreign-trained physicians, many of whom came in through the Labor Department, not as physicians, but as filling a labor shortage area.

This atmosphere of rapidly training physicians was not in the best interest of society, for it tended to lower the quality of medicine.

Along with the acceleration, the rotating internship was abolished and in lieu of this training, the last year of the curriculum was altered so that a clerkship for clinical training was established.

### Compassion and Understanding

Without maturity, it is the unusual physician who has compassion and understanding of the sick person.

By 1975, we had more than 50,000 new physicians, but the same problem existed, that of maldistribution.

It would appear that the pendulum is swinging towards conservatism. State medical licensing boards have become more strict over the years, and federal legislation has been passed so there will be more selectivity among foreign graduates.

Educators are recognizing the fact that a physician, in order to graduate, should have at least four years of undergraduate studies, and four years of postgraduate studies.

A few years ago, the Secretary of the Association of American Medical Colleges told me that, at that time, there were only three medical schools which accepted students with less than a bachelor's degree, and, as far as he was concerned, there should be none.

This move towards conservatism also will be seen in our inter-physician relationship. The referring physician will become less likely to send a patient who is in need of surgery to one who tends to be radical in his surgical approach.

As a urologist, I have particularly noted this trend towards less extensive surgery in the treatment of carcinoma of the prostate and carcinoma of the bladder.

The move toward less radical surgical treatment in carcinoma of the breast and other corrective procedures is well known. Approximately 20 years ago at a meeting of the American Cancer Society in Washington, D. C., I heard Dr. George Crile, Sr., say, "There should be an investigative body named to study the mortality and morbidity of the unnecessary diagnostic and surgical procedures for malignancy."

### Medicine Finds The Answer

How prophetic he was. We do not have such a commission, but medicine itself is finding the answer. Physicians are becoming more considerate of human tissues, and the value placed on each day that man lives a fairly comfortable life.

It is my hope that this wave of conservatism not only will affect the practice of medicine, but also will be noticeable in our everyday living habits.

Scientists today more and more are accepting the fact that life as we know it is existent only on this planet. They point out that the earth is a narrow window rotating around the sun, and that if it were one degree closer to the sun our earth would be a desert, and if it were one degree farther away it would be a frozen mass.

These facts lend support to the Book of Genesis in the Bible, which states that God created the world in which we live. Following this creation, he brought into this earth, man, and all living and plant life.

Along with this wave of conservatism, there is bound to be a resurgence of our spiritual beliefs. Both conservatism and strong religious principles are in the best interest of our patients and the doctor-patient relationship.

I have often been asked why I titled my book, "God, Man and Medicine."

My answer is always quite simple.

"Man comes before medicine, and God is over all."

*A message from . . .*

*The President*

## A PERSONAL INVITATION

I think AMA membership is important to every physician. In my travels about the state I have been attempting to promote that membership.

The first time I discovered that more than one-third of our state members do not belong to the AMA, I was surprised. The surprise quickly soured into disappointment and then gradually matured into curiosity.

Is it cost? Policy or philosophical disagreement? Are they just disinterested? Maybe no one ever asked them to join.

Covering the last possibility first, I have been asking, and I think, to a certain extent, it is true that no one ever asked some of them to join—at least, personally or directly. We all get letters from time to time asking us to join something or other. I plan to ask every doctor in this state who is not a member of AMA to become one.

I can't really believe it is disinterest. Every bit of evidence is to the contrary. In fact, the non-members I get to talk to are some of the most interested, and most verbal, in discussing many of the crucial problems with which the AMA struggles on a daily basis. Quite frankly, such discussions and correspondence have turned out to be the most stimulating part of this presidential job.

Most non-members talk to me about their policy or philosophical disagreements with the AMA—the organization just does not represent their interests, they say. I then ask, who does represent their interests? There is usually a long pause at about this point. There is no organization other than the AMA which represents the interests of American physicians. No other organization has ever even been suggested which might do this. The AMA represents all of us whether we like it or not.

There is no other forum, no other game in town, for battling out disagreements. If you have disagreements, the only alternative to joining, debating and changing things is to retire to your cave to sulk. The AMA is painfully democratic, and I can assure you that policy changes do occur in response to member persuasion.

Yes, it is expensive and likely to get more so. But what isn't these days? A more important consideration is—is it worth it? I think it is. It's a bargain. When you get right down to it, that whole organization is out there defending just you and your right to practice medicine free from the intrusiveness and unreasonable interference of all manner of controlling and regulating mechanisms which otherwise would afflict you. They are also aiding you in innumerable ways to practice the best brand of medicine of which you are capable.

I've seen some of you. I'm looking forward to seeing the rest of you. I'll be asking you then as I am now to join the rest of us in the American Medical Association.

I am available at any time by phone, letter or in person to discuss this in any detail with all of you.

Stephen D. Ward, M.D.

STEPHEN D. WARD, M. D., *President*

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

## MEDICAID NEEDS CRITICAL CARE

The West Virginia Medicaid Program is sick! It is time to call family members to the bedside.

In the June and July, 1979, issues of *The Journal* we identified the basic pathology. The Medicaid Program found itself some 10 million dollars underfunded in state money as the current fiscal year began last July 1, after running out of funds in late May of last year. Like the symptoms of dehydration following closely on a bad case of dysentery, the 1979-80 fiscal situation simply has worsened the 1978-79 malady, and the prognosis has steadily deteriorated.

A bit of background:

1) The Department of Welfare knew it could not fund the medical services program through the final months of fiscal 1978-79, so it asked the 1979 Legislature for an additional 4.7 million dollars in state money to get through last June 30;
2) The Legislature provided $2.5 million;
3) A $2.2 million-dollar shortfall in state funds ensued, paid for out of fiscal 1979-80 funds;
4) The Welfare Department asked for 37.3 million dollars in state funds for medical services in 1979-80;
5) The Legislature appropriated 30.5 million dollars.

The 2.2 million-dollar shortfall, added to the 7 million dollar deficiency in appropriations for fiscal 1979-80, equals a current deficit of 9.2 million dollars needed to fund the remainder of fiscal 1979-80.

Governor Rockefeller's budget as prepared for the 1980 Legislature proposed a supplemental appropriation of 8 million dollars to offset this 9.2 million-dollar shortfall. But as a result of controversy too complex to cover here, only some fraction of that inadequate amount might be funded. The Administration and the Legislature seem determined to outdo one another in creating mischief in the Welfare Department.

It has been *The Journal's* opinion that the 8 million dollars will be inadequate—and the same opinion holds for the 45 million dollars recommended by the Governor for 1980-81—to continue even at a minimum the current services the program embraces.

*The Journal* has in the past contended that when the legislative and executive branches of government promise the people services, they have an indisputable obligation to fund them adequately and effectively.

We have pointed out the distasteful likelihood of a de facto establishment by government of a two-tiered system of medical care, one for the rich and one for the poor, by a failure to fund adequately those medical programs already established by government upon which our less fortunate citizens have been induced to rely. Our present concerns about the imminence of such a misfortune cannot be overstated!

Welfare Commissioner Leon Ginsberg—who in all fairness is catching heavy flak for inadequate cost estimates prepared by others for the medical program—has given legislators a sample of options he feel his department will have to follow if supplemental funds for 1979-80 are not provided. All options presented are onerous.

Under one, to save 9.2 million dollars the department would:

1) Delete its pharmacy program for the aged;
2) Terminate its general assistance stop-gap and emergency medical program;
3) Drop the medically needy program now serving some 15,000 individuals;
4) Discontinue dental and optometric services for adults;
5) Stop intake in its handicapped children program;
6) Limit hospital coverage to 30 days a year;
7) And reduce by 23 per cent payments to all providers, including physicians, except those for inpatient hospital care which are set by other requirements.

A second option, to save 10.1 million dollars, would delete the medically needy program and intermediate nursing home care. The third option, designed to save 10.5 million dollars, would delete all pharmacy services and intermediate nursing home care.

The West Virginia Medicaid Program is indeed sick. Its profound anemia desperately requires a transfusion of money. Comments on the political consequences of a failure to provide this therapy would be gratuitous on our part.

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**HOW NOT TO LOBBY**

For a textbook kind of example of how *not* to go about trying to get legislation passed, one needs to look no further than the disaster the Carter Administration brought down upon itself in recent U. S. House of Representatives action on its hospital cost-containment bill.

Simply stated, the Administration made about every possible mistake in trying to sell a bad, loop-hole bill that critics effectively contended would necessitate another costly layer of bureaucracy to interpret and implement.

The Administration, of course, blamed a 68-vote rejection of its measure in favor of a substitute recognizing voluntary efforts to control costs on "well-financed, special-interest lobby groups," such as the American Medical Association, American Hospital Association and several others.

The White House conveniently ignored its own all-out blitz, with labor as a close compatriot, to line up votes for its side. The President had made the hospital bill the cornerstone of his anti-inflation program, insisting that its passage was an absolute necessity before national health insurance could be considered seriously.

The House vote offers a key lesson that can, and must, be applied everywhere. Organization and all-out legislative efforts are fine as well as essential—but you must have a quality product to sell, and you must know how and when to sell it. The Administration scored an "F" in this general area.

There clearly were not enough votes in the House Rules Committee to get the bill to the floor in the manner in which Carter desired—in a posture where no amendments could be offered or considered. House Democratic leaders warned the President and his aides that was the case. But Carter still sent word to the leadership to schedule a vote.

House Speaker Thomas (Tip) O'Neill, Massachusetts Democrat pledged to support the Administration, broke all rules of pre-vote strategy by telling reporters that Carter was going to lose on the floor by an "overwhelming" margin. He was right, although O'Neill made a valiant effort with a stem-winding speech in support of the bill.

The complexity of the Carter proposal, laced with exceptions from cost containment provisions clearly designed to get votes, provided opponents with a field day. They hit hard at allegations the administration bill would impose burdensome red tape on hospitals that would lead to higher regulatory costs; and that it would stifle purchase of quality equipment and services, leading to a rationing of health care.

Obviously, we haven't heard the last of this issue. Carter, himself, has said so. But the Administration will need a much better set of ducks, lined up in much better fashion, to carry the day. And that's what the legislative process should be all about.

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**PUBLIC SERVICE EMPLOYEE UNIONS**

Again within the legislative maze at present is a bill that would authorize the establishment of public service employee unions in West Virginia.

The mere presence of such a proposal before a legislative body gives a certain stature and aura of acceptability to the concept it does not deserve. The possibility that it could receive serious consideration is in itself an unflattering indictment of those members of the Legislature who would give it serious consideration. It suggests that, for the price of support of those would-be union brethren, some of our elected officials might sell out or abandon their responsibilities to govern this state.

The statutory acceptance of such a union very clearly establishes legally a union's right, protected under labor laws, to anarchism. Its members can defy government. Its members can thumb noses at laws which bind the rest of us. Outside any form of representative democracy, such a union can force the imposition of taxes on all citizens of the state to meet its bargaining table demands.

By the time this is printed, we perhaps will have heard all of the pious speeches about a "no strike clause" and the responsibility, dedication and patriotism of our public employees. We are sure they support the flag and mother-

hood, help little old ladies cross the street and love little children. We are also sure they will strike, given the first opportunity.

Any who have doubts about the certainty of public employee strikes need only read the daily newspapers. "Blue flu's", "sickouts" and "job actions" in other states by police, firemen, teachers, welfare workers, prison guards and state hospital employees have been in the news within very recent memory.

We need look no further than our own Wetzel County, where attempts by hospital employees to set up a public service employees' union have led to a prolonged strike with all of the attendant hardship and suffering endured by everyone in the area. With utter cynicism, union spokesmen state that the strike has as its aim the provision of better and more reliable care to the patients at Wetzel County Hospital.

Sedition and treason are terms which come to mind designating acts promoting and leading to lawlessness, violence, disorder and resistance to organized government. Are we now in West Virginia to give a license for acts which formerly merited hanging?

If so, our decision can only stem from a universal loss of respect for government so profound that anarchy is an acceptable and, perhaps, a welcome alternative.

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**THE HUMAN FACTOR DIMINISHING**

We commend for your careful, and thoughtful, reading a special article in this issue of *The Journal*—"The Human Factor," by Charles A. (Carl) Hoffman, M. D.

The author needs no introduction. His long professional career, reflecting ultimate dedication to his patients, has been supplemented by top responsibilities in organized medicine, and in specialty society activities, at state, national and international levels.

No one is better qualified to say what this special article says. There are few who might say these things better. And some observations Doctor Hoffman has offered deserve to be made again and again.

Much of the article deals with trends and philosophy related to medical education. At the American Medical Asociation and other levels, this is a top priority item of an admittedly complex and controversial nature. Doctor Hoffman's thoughts are thus most timely, and—from the background in which they are offered—deserving of thorough review.

His observations about physician-patient communications—what is perhaps most commonly called "rapport"—rate at least equal thought. He sees "no doubt that there has been a lessening of communications between the patient and his physician."

Doctor Hoffman concedes that this is understandable in a world of ever-changing values—but he then asks a most pertinent question: "If our world is changing, why is not the human factor improving rather than diminishing?"

The author concedes that some of the things he says relative to what he sees as deteriorating public relations climate won't set well with some of his colleagues.

But there are some problems which just can't be explained away by the admittedly heavy pressures under which physicians live daily, and the general stress and demands they face.

The State Medical Association's Headquarters Office has had an instance in recent weeks in which it was told by personnel in a physician's office that the doctor "does not have time to return calls." Incidentally, a call was not returned.

We know that's an exception. But there's a problem of at least some significance. Doctor Hoffman recognizes it. So do others, including patients.

## *Our Readers Speak*

### Another Accomplishment

I was very sorry to see that Dr. E. J. Van Liere had died.

The write-up about him on page 306 of *The West Virginia Medical Journal* for October, 1979, did not mention one of his outstanding accomplishments, namely the affiliation in 1944 of the West Virginia School of Medicine with the Medical College of Virginia.

Through this affiliation, arranged by Doctor Van Liere and the late Dr. W. T. Sanger, President of the Medical College of Virginia, a number of graduates of West Virginia University's two-year school joined MCV's junior class and progressed to graduate from MCV. This relationship was discontinued in 1962 with the development of the four-year school at WVU.

During its 18 years this program allowed MCV to claim as alumni many illustrious West Virginians such as A. Thomas McCoy, Joseph A. Smith, and Robert D. Hess. (*Editor's Note*: Doctors McCoy, Smith and Hess are, of course, Past Presidents of the West Virginia State Medical Association.)

Kinloch Nelson, M. D.
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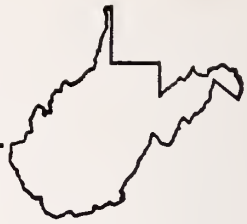
# GENERAL NEWS



## Maryland Dermatologists To Talk During Annual Meeting

Two dermatologists from the University of Maryland School of Medicine, in Baltimore, will speak during the Thursday morning, August 21, general session of the State Medical Association's 113th Annual Meeting.

Harry M. Robinson, Jr., M. D.

Joseph W. Burnett, M. D.

The two lecturers will be Drs. Harry M. Robinson, Jr., Professor and former Head of the Division of Dermatology, and Joseph W. Burnett, Professor and currently Head of Dermatology, it was announced by the Program Committee.

The convention will be held August 20-23 at the Greenbrier in White Sulphur Springs.

Doctor Robinson will speak on "Advances in Photochemotherapy," while Doctor Burnett's topic will be "Diagnostic Dermatologic Methods."

Convention activities will get under way with a 2 P. M. meeting of the Association's Executive Committee on Tuesday, August 19; the usual pre-convention meeting of the Council at 9:30 A. M. on Wednesday, and the opening session of the House of Delegates at 3 P. M. on Wednesday.

Doctor Robinson headed the Division of Dermatology at the University of Maryland from 1954 until 1977, when he was succeeded by Doctor Burnett.

He is the author of some 110 scientific articles and three books. In addition, he has co-authored two books with Doctor Burnett.

Doctor Robinson is a Past President of the Baltimore-Washington Dermatologic Society, the Baltimore Dermatologic Society, the Southeastern Dermatologic Conference, and former Chairman of the Advisory Committee to the U. S. Food and Drug Administration for the American Academy of Dermatology.

He has received four awards from the American Academy of Dermatology.

A native of Baltimore County, Doctor Robinson received his M. D. degree in 1935 from the University of Maryland.

He was certified by the American Board of Dermatology in 1946.

### Yale, Harvard Graduate

A Diplomate of the American Board of Internal Medicine and the American Board of Dermatology, Doctor Burnett served as President of the Maryland Dermatological Society two times (1969, 1973).

He was graduated from Yale University and received his M. D. degree in 1954 from Harvard Medical School. A native of Oil City, Pennsylvania, he is a member of a number of research and honorary societies.

Doctor Burnett is the author or co-author of 119 articles and papers.

As announced previously, Dr. Robert B. Hunter of Sedro Woolley, Washington, who will be installed as the President of the American Medical Association in July, has been invited to address the first session of the House of Delegates on Wednesday afternoon.

### JAMA Editor to Speak

Delivering the keynote Thomas L. Harris Address during 9 A. M. opening exercises on Thursday, also as announced previously, will be Dr. William R. Barclay, Editor of The Journal of the American Medical Association (JAMA). The first general session will be held immediately following the opening exercises, with general sessions also scheduled for Friday and Saturday mornings.

In addition to the talks by Doctors Robinson and Burnett, there will be a paper on foods and

medications during the first general session and, during the Friday morning session, presentations on psychiatry and children's learning disorders.

The Saturday morning session will feature talks on AMA services and the activities of the AMA's Washington office.

The general convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 22).

#### To Install Doctor Fix

Plans also call for the usual President's Reception on Wednesday evening, August 20, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P. M. on Saturday. At that House session, Dr. L. Walter Fix of Martinsburg will be inaugurated as President to succeed Dr. Stephen D. Ward of Wheeling.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. D. Sheffer Clark of Huntington in charge as the Auxiliary's President, again will run concurrently with the Association's convention.

More specific information relative to other general session topics and speakers will be provided in upcoming issues of *The Journal.*

Members of the Program Committee are Dr. M. D. Reiter of Wheeling, Chairman; Doctor Fix, and Drs. David K. Heydinger of Marshall University's School of Medicine in Huntington; Joseph B. Reed, Buckhannon; Stanley Roy Shane of the West Virginia School of Medicine faculty in Morgantown, and John F. I. Zeedick of South Charleston.

## 'Tremendous' Response To MU Diabetes Clinic

The Diabetes Clinic, established by the Marshall University School of Medicine in conjunction with Family Care Outpatient Clinic (FCOC), has been expanded to two days a week, Dr. Bruce S. Chertow, MU Professor of Medicine and Chief, Section of Endocrinology, announced.

"Since we began offering the Diabetes Clinic once a week last spring we found that there is a need to increase our capacity to see patients with diabetes," Doctor Chertow said. "The community response and the physician support of this program has just been tremendous."

**The descendants of Dr. Lake Polan, an early Huntington oculist and pioneering optics industrialist, and his wife, Bertha Handler Polan, have established the first endowed chair at the Marshall University School of Medicine. The Lake Polan, M. D., and Bertha M. Polan Chair in Ophthalmology was endowed by the family with a commitment of $100,000 minimum. Dr. Charles M. Polan, center, a Huntington ophthalmologist, recently initiated the endowment on behalf of the family with a check presented to MU Foundation Executive Director Bernard Queen, left, with School of Medicine Dean Robert W. Coon, M. D., looking on.**

The Diabetes Clinic is now in operation from 9 A. M. to noon on Mondays and Thursdays. Assisting Doctor Chertow and supervising the Monday clinic will be Dr. Nicholas G. Baranetsky, MU Assistant Professor of Medicine.

"The clinic was started to assist diabetic patients referred to us by their own physicians in adjusting to their illness," Doctor Chertow said. "We also offer another support service — the Diabetic Hotline—for those with questions or problems related to their illness," he added.

The hotline is in operation from 8:30 to 9:30 A. M. on Tuesdays and Fridays. The number is 696-5233.

"Basically, the clinic and hotline services are continuing education programs for the diabetic patient, with the hotline providing an additional communications link to emergency medical assistance," Doctor Chertow said.

## Dr. Richard Flood To Chair New Planning Committee

Dr. Richard E. Flood of Weirton will chair a new Medical Association Committee on Long-Range Planning, Dr. Stephen D. Ward of Wheeling, the Association's President, told Council at its January 13 meeting in Charleston.

Council authorized appointment of the ad hoc committee at its November, 1979, meeting to develop Association goals, objectives and priorities for the years ahead—in connection, in large measure, with other plans to build an Association headquarters.

Doctor Ward said that others serving on the committee with Doctor Flood, a Past President of the Association, would be Dr. John B. Markey of Charleston, the curent Vice President; Dr. Harry Shannon, a Councilor from Parkersburg; Dr. Louis C. Palmer of Bridgeport, and Dr. John A. Mathias of Buckhannon.

Doctor Ward also announced re-appointment of the entire committee which plans the annual Mid-Winter Clinical Conference in Charleston. That group includes Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston, Co-Chairmen; William O. McMillan, Jr., of Charleston; Maurice A. Mufson of Huntington; Robert L. Smith of Morgantown, and C. Carl Tully, South Charleston.

In other matters on the Council agenda, it:

—Elected Drs. William D. McClung of Lewisburg (Greenbrier Valley Society) and William T. Lawson, Fairmont (Marion) to honorary membership; and Drs. Willard Pushkin of Charleston and Joseph P. Seltzer, Atlanta, Georgia (both Kanawha Medical) as retired members.

—Approved several allocations of funds for the Association's Annual Meeting in August at the Greenbrier in White Sulphur Springs, including $1,750 to the Association Auxilary to help offset its convention costs.

**Shown in the left photo are some of the speakers for the session on "Infectious Diseases Update" during the 13th Mid-Winter Clinical Conference held January 25-27 in Charleston at the Holiday Inn Charleston House, and other physicians. From left, are Drs. Maurice A. Mufson, Huntington, a member of the Program Committee; Stephen M. Feinstone, Bethesda, Maryland, a speaker; Thomas W. Mou, Charleston, who presided; John C. Partin, Cincinnati, a speaker, and Ralph H. Nestmann, Charleston, Co-Chairman of the Program Committee. In the right photo, the third speaker for the session, Dr. Robert H. Waldman (left), Morgantown, is shown with Dr. Robert D. Hess, Clarksburg, Chairman of the State Medical Association's Council.**

—Heard an update on legislative matters, and voted not to oppose proposed legislation to revise the composition of medical service corporation (Blue Shield) boards to provide for a majority other than one—as required by current law—made up of duly licensed physicians.

Council also heard progress reports on property acquisition and further plans for a headquarters building; work by a committee studying possible alternative sources for professional liability insurance coverage for Association members; and continued development of a program spawned by the Association to provide new medical rehabilitation facilities and services in West Virginia communities.

## Pediatric Pulmonary Seminar Planned In Pittsburgh

A two-day Pediatric Pulmonary Seminar will be held April 11-12 at the Pittsburgh Hyatt House at Chatham Center, in Pittsburgh.

The American Lung Association of West Virginia, along with several other health organizations in Pennsylvania and Ohio, is sponsoring the program.

Featured among the faculty members will be Douglas Holsclaw, M. D., of Hahnemann Hospital, Philadelphia; Henry Levison, M. D., Professor of Pediatrics at the Hospital for Sick Children, Toronto, and Etzuro K. Motoyama, M. D., Professor of Anesthesiology and Pediatrics at Children's Hospital, Pittsburgh.

The seminar will include plenary sessions as well as opportunities for several one-and-one-half-hour conference sessions. Among the topics to be discussed in the plenary sessions are: factors in development of lung disease, developmental susceptibility to lung injury, bacterial infections, tuberculosis, cystic fibrosis, bronchiolitis and asthma.

In addition, participants may attend several clinical chest conferences. Topics will include: neonatal pneumonias; practical utilization of theophline; epiglottitis, croup and other airway problems; acute lung injury; evaluation of pulmonary function in children; radiologic interpretation of the chest, and coping with chronic lung disease.

The cost for the program is $75 for physicians and $50 for nurses, therapists and residents. To avoid any late assessment fee, reservations should be made by April 2. For registration and other information, contact Pediatric Pulmonary Seminar, Marcy Building, 2851 Bedford Avenue, Pittsburgh, Pennsylvania 15219. Telephone (412) 621-0400.

The other sponsors are the Christmas Seal League of Southwestern Pennsylvania, Ohio Lung Association, Pennsylvania Lung Association, Pennsylvania Thoracic Society, Southwestern Pennsylvania Lung Association and University of Pittsburgh School of Medicine.

## State, Pennsylvania Surgeons Schedule May Meeting

"Vascular Surgery in the Greenbrier Valley During World War II" will be the lead-off subject for the meeting of the West Virginia Chapter, American College of Surgeons May 1-3 at the Greenbrier in White Sulphur Springs.

Meeting with the West Virginia Chapter will be the Southwestern Pennsylvania Chapter.

Presenting the paper on the above topic will be Dr. James P. Boland, Professor and Director of Surgery, Charleston Division, West Virginia University Medical Center.

Other speakers and topics scheduled for the opening day, May 1, will be "The Rising Incidence of Malignant Melanoma in West Virginia" —Kenneth S. Scher, M. D., Assistant Professor of Surgery, Marshall University School of Medicine; "Recent Advances in Diagnostic Urology"

**The 13th Mid-Winter Clinical Conference held in January in Charleston featured both public and physicians' sessions on "Drug Abuse, Smoking and Alcoholism." Shown above are two of the speakers for those sessions, Jack M. Rogers, M. D., left, Winston-Salem, North Carolina, and Daniel Horn, Ph. D., Frenchtown, New Jersey.**

—John A. Belis, M. D., WVU Assistant Professor of Urology;

"Surgical Management of Phenochromocytoma"—H. William Scott, Jr., M. D., Professor of Surgery and Director, Section of Surgical Sciences, Vanderbilt University; and "Mental Confusion in the Surgical Patient"—John O. Mullen, M. D., MU orthopedic surgeon.

The May 2 program will be conducted by the Southwestern Pennsylvania Chapter, and will include a presentation on "Morbid Obesity—A Surgical Disease?" by Ward O. Griffen, M. D., Professor and Chairman of Surgery, University of Kentucky.

A panel on "Cardiac Surgery in West Virginia," moderated by Dr. John D. Harrah of the MU surgical staff, will constitute the May 3 program.

Speakers and topics for the panel will be "Coronary Artery Surgery"—Lorraine J. Rubis, M. D., MU surgeon; "Surgical Correction of Congenital Heart Defects"—Herbert E. Warden, M. D., WVU Professor and Vice-Chairman of Surgery; "Surgical Treatment of Valvular Heart Disease"—James H. Walker, M. D., Charleston;

"Treatment of Hand Injuries"—D. Verne McConnell, M. D., and David A. Kappel, M. D., Wheeling plastic surgeons, and "Present Role of Vagotomy in Duodenal Ulcer Disease"—Doctor Scott.

The meeting also will include the presentation of first-, second- and third-prize papers by residents.

## Mid-Winter Conference Attendance 231

Total registration was 231 for the 13th Mid-Winter Clinical Conference held January 25-27 in Charleston at the Holiday Inn Charleston House.

Of the 231, 208 were physicians, including 16 residents. The other registrants included medical students, nurses, physicians' assistants, and exhibitors.

The total registration for the 1979 meting was 241.

The annual continuing education event is sponsored by the West Virginia State Medical Association and the West Virginia and Marshall University Schools of Medicine.

# Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

| | | |
|---|---|---|
| Mar. 21 | Charleston | 7th Annual Newborn Day |
| Mar. 28-29 | Morgantown | Neurosciences Teaching Day |
| April 18 | Morgantown | 6th Annual ENT Teaching Day |
| April 19 | Wheeling | Annual Postgraduate Day in Surgery |
| April 26 | Morgantown | W. Va. Assn. of Pathologists, Scientific Session |
| May 8-9 | Morgantown | Health Officers Seminar |
| June 7 | Morgantown | Anesthesia Update '80 |
| June 7 | Charleston | 7th Annual Surgery Conference |

**Visiting Professors**

(Morgantown)

April 3-4 *Dept. of Obstetrics and Gynecology*: "Perinatal Outcome in Pregnant Epileptics" and "Hyperthyroidism in Pregnancy," Luis B. Curet, M. D., University of Wisconsin, Madison.

April 18 *Dept. of Radiology*: Melvin Clouse, M. D., Chairman, Department of Radiology, New England Deaconess Hospital, Boston.

May 16 *Dept. of Radiology*: David H. Baker, M. D., Professor and Director, Pediatric Radiology, The Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City.

May 29-30 *Dept. of Obstetrics and Gynecology*: "The Obstetrician's Unique Challenge—Conflicting Risks of Two Patients" and "Premature Rupture of the Membranes," Watson A. Bowes, M. D., University of Colorado, Denver.

*Dept. of Anesthesia*: One Thursday each month, 4 p.m.

*Dept. of Medicine*: Variable—incorporated in Grand Rounds

*Dept. of Family Practice*: Variable—incorporated in Grand Rounds

## Medical Education–Licensure Dilemmas Meeting Theme

The 76th Congress on Medical Education will be held April 24-26 in Chicago.

Co-sponsors of the Congress are the American Medical Association, the Association for Hospital Medical Education, and the Federation of State Medical Boards of the United States.

Theme of the Congress will be "Dilemmas of the Decade—Medical Education and Licensure."

Dr. Donald Kennedy, Vice President and Provost, Stanford University, former Commissioner of the U. S. Food and Drug Administration, will be the keynote speaker at the opening session. Heading a panel on generalism and specialism during the first morning's program will be Norman Cousins, Chairman of the Editorial Board, *Saturday Review*, and Senior Lecturer in Medical Humanities, University of Southern California at Los Angeles School of Medicine.

Newton Minow, senior partner of the law firm of Sidley and Austin, Chicago, and former Chairman of the Federal Communications Commission, will deliver the major address of the second day's session, speaking on "The Regulation of Medicine."

Theodore Cooper, M. D., Dean at Cornell University Medical Center, former Assistant Secretary for Health of the U. S. Department of Health, Education and Welfare, will keynote a session with an address on "Factors Affecting Medical Progress."

Groups of distinguished panelists will join the keynote speakers in expanding on various aspects of the convention theme of the dilemmas facing medical education and licensure of physicians.

Appearing with Mr. Cousins will be William D. Holden, M. D., Chairman of the National Board of Medical Examiners; Herbert A. Holden, M. D., Past President of the American Academy of Family Practice, and John M. Eisenberg, M. D., of the University of Pennsylvania School of Medicine.

A panel on Public and Professional Perspectives will include Donald S. Winston, M. D., Chairman of the former AMA Resident Physician Section's Workshop on Cost Containment; Robert T. Kelly, M. D., Chairman of the AMA Council on Medical Service; Hugh Tilson, M. D., Director, Department of Health Services, State of North Carolina, and Henry G. Cramblett, M. D., Dean, Ohio State University College of Medicine.

On the panel with Mr. Minow will be Thomas B. Ferguson, M. D., President, Council of Medical Specialty Societies; E. Harvey Estes, M. D., Chairman, Department of Community and Family Medicine, Duke University Medical Center; Howard G. McQuarrie, M. D., of the Utah Board of Registration; John H. Morton, M. D., Past President, Federation of State Medical Boards.

**Dr. Tracy N. Spencer, left, of Charleston chats with Dr. Maxwell N. Weisman of Baltimore. Doctor Weisman was a speaker for sessions on "Drug Abuse, Smoking and Alcoholism" during the recent 13th Mid-Winter Clinical Conference held in Charleston.**

and John C. Sage, M. D., of the Nebraska Board of Medical Licensure.

The panel with Doctor Cooper will include Robert S. Stone, M. D., Dean of Texas A & M College of Medicine, and Geoffrey Segar, Indianapolis attorney.

Congress registrants may attend all-day workshops sponsored by the Federation of State Medical Boards of the United States on Wednesday, April 23, and a 50th Anniversary Symposium on Allied Health sponsored by the AMA on Friday and Saturday, April 25 and 26. A workshop on graduate education also will be offered Firday afternoon. April 25.

Further information on the Congress is available from the office of Dr. John Fauser, Group on Medical Education, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

## MU To Offer Community Health Degree

The Marshall University School of Medicine will offer a Master of Science degree in Community Health, beginning with the first summer term of 1981.

Approval of the program by the West Virginia Board of Regents in its meeting in February was announced by MU Provost Olen E. Jones, Jr., and Graduate School Dean Paul D. Stewart.

**Drs. Jack R. Page (center) and William H. Carter, both of Charleston, demonstrate intubation techniques on a mannequin during the CPR and ACLS Workshop held during the recent 13th Mid-Winter Clinical Conference in Charleston. Looking on is Diana Russell, Basic Life Support Coordinator for Emergency Medical Services Operation, Region 34, Inc. (EMSOR, Inc.) of Charleston.**

"In keeping with Marshall's goal of educating primary care specialists, this master's program will serve to supplement the resident's clinical skills with those nonclinical skills necessary to a medical practice responsive to community health care problems," Doctor Jones said.

The new master's-level program is a component of the recently-established Combined Residency/Practice Program and will be open only to those holding the Doctor of Medicine degree who are resident physicians in primary care specialties—Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics and Psychiatry, according to Doctor Stewart.

The Combined Residency/Practice Program offers physicians both an intensive residency program in their chosen primary care specialty and an opportunity to practice medicine in a rural outreach setting.

### Underserved Communities

"The Combined Program concept, conceived by Dr. David K. Heydinger, Marshall Medical School Associate Dean for Academic and Clinical Affairs, and developed in cooperation with the medical school's faculty, is another step in meeting our commitment to solving the underserved communities' medical needs through the school's educational program," according to MU Vice President for Health Sciences Robert W. Coon, M. D., who also serves as School of Medicine Dean.

"Within 18 months of the implementation of the Combined Residency/Practice Program, we will begin placing physicians, who are specifically educated to meet rural health care needs, in medically-underserved areas of West Virginia," the Vice President/Dean said.

Describing the relationship of the master's degree work to the Residency/Practice Program, Doctor Heydinger said:

"While the residency clinical training provides skills and attitudes in individual patient care, the master's curriculum is concerned with community, interpersonal, business and leadership skills. It is designed to provide the basic research methods necessary for quality investigation of community health and to encourage that spirit of inquiry."

The master's degree curriculum includes courses in Appalachian studies, health care administration, health care research methods, health statistics, epidemiology and community health care monitoring.

**Appalachian Situations**

Many of the courses take a case-study-problems approach in which residents are to investigate relevant Appalachian health care situations. In addition, each resident will be required to prepare a thesis dealing wtih a selected community health care topic.

"Marshall's proximity to medically-underserved areas of West Virginia makes it a logical site for a master's program in community health skills," Doctor Heydinger said. "This program, with its constant interaction with local health problems of southern West Virginia, will bring the skills and knowledge of the medical school to where they are most needed."

## Memorial Anesthesiology Prize Established At WVU

The Department of Anesthesiology, West Virginia University School of Medicine, and the West Virginia State Society of Anesthesiologists have established the William Bennett Prize in Anesthesiology.

Bennett, a fourth-year medical student at WVU, died in early January as the result of an automobile accident.

Richard B. Knapp, Professor and Chairman of Anesthesiology, said the memorial prize of $100 would be given each year to the senior medical student most deserving in anesthesiology.

**Enjoying a conservation during the 13th Mid-Winter Clinical Conference held recently in Charleston are Drs. Stephen D. Ward, left, of Wheeling, President of the State Medical Association, and Jean P. Cavender, Charleston.**

## Physicians' Child Abuse Course Offered

A conference on Child Abuse, addressed to physicians, will be held on April 12 in Room 2W37 of the Marshall University Student Center from 9 A. M. to noon.

The sponsor is the West Virginia Branch of the American Medical Women's Association.

Speakers will include Barbara L. Tenney, M. D., Associate Professor of Pediatrics, West Virginia University School of Medicine, Morgantown; Kenneth M. Fink, M. D., Huntington Psychiatrist, Child and Adult; Henry Staub, M. D., MU Department of Pediatrics; Robert W. Lowe, M. D., Huntington Orthopedic Surgeon; F. Jane Hustead, L. L. B., Huntington, and Eleanor Moser, Occupational Therapist, organizer of Parents Anonymous in Huntington.

The subject of Child Abuse will be approached from the standpoint of physicians, and physicians as child advocates, including defining, reporting and treatment of the abuser and abusee, according to Dr. Florence K. Hoback, M. D., Huntington psychiatrist. Doctor Hoback is President Elect of the West Virginia Branch.

Appropriate continuing education credit for the three-hour course is being sought, she said.

## *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*The Nervous System, 2nd Edition*, by William F. Ganong, M. D. 243 pages. Price $11. Lange Medical Publications, Los Altos, California 94022. 1979.

*Current Surgical Diagnosis and Treatment, 4th Edition*, by J. Englebert Dunphy, M. D., and Lawrence W. Way, M. D. 1162 pages. Price $19. Lange Medical Publications, Los Altos, California 94022. 1979.

*Current Medical Diagnosis & Treatment*, by Marcus A. Krupp, M. D., and Milton J. Chatton, M. D. 1116 pages. Price $19. Lange Medical Publications, Los Altos, California 94022. 1980.

## Child Abuse To Be Discussed At Pediatrics Meeting

"Child Abuse in West Virginia and the General Pediatrician's Role" will be the title of a talk to be given during the spring meeting of the West Virginia Chapter, American Academy of Pediatrics.

The meeting will be held April 10-11 in Charleston at the Holiday Inn Charleston House.

Dr. Barbara L. Tenney, Associate Professor of Pediatrics, West Virginia University School of Medicine, Morgantown, will present the talk noted above.

Dr. Alan D. Rogol of the University of Virginia will speak on endocrine topics and, specifically, "Short Stature."

Other speakers were to be announced.

For additional information, contact Dr. Thomas G. Potterfield of Charleston, Program Chairman.

Serving on the program committee with Doctor Potterfield are Drs. M. B. Ayoubi, Herbert H. Pomerance, George A. Shawkey and Edwin P. Stabins, all of Charleston.

## Doctor-Placement Directories, Brochures Available

New editions were off the press in February of the American Medical Association's publications aimed at helping communities and others find a doctor and at helping doctors find the proper place to practice.

As an aid to communities and others seeking doctors, the February, 1980, *Physician Placement Register* lists thousands of physicians who are seeking new professional positions.

Recruiting physicians can pose special problems for institutions and communities. The potential difficulties, as well as some answers and alternatives, are outlined in the AMA's Physicians' Placement Service "Action Plan for Physician Recruitment."

To aid doctors seeking a practice location, the February, 1980, *Opportunity Placement Register* lists openings for physicians indexed by specialty, type of practice, date of availability, financial arrangements, location and size of community and other data.

Also available is a new brochure entitled, "A Physician's Guide to Finding a Place to Practice."

Copies of these publications are available from the Physicians' Placement Service, American Medical Association, 535 N. Dearborn Street, Chicago, Illinois 60610.

# *Medical Meetings*

March 9-13—Am. College of Cardiology, Houston.

March 19-21—Am. Society for Clinical Pharmacology & Therapeutics, San Francisco.

March 23-27—Am. College of Surgeons, Toronto.

April 2-8—Am. College of Allergists, Washington, D. C.

April 10-11—W. Va. Chapter, Am. Academy of Pediatrics, Charleston.

April 11-12—W. Va. Assn. of Blood Banks, Parkersburg.

April 11-12—33rd. Annual Stoneburner Lecture Series, Med. College of Va., Richmond.

April 11-12—Pediatric Pulmonary Seminar (Am. Lung Assn. of W. Va., etc.), Pittsburgh.

April 12—Child Abuse Conference (W. Va. Branch, Am. Med. Women's Assn.), Huntington.

April 17-18—Rural Health Conference, Boston.

April 17-20—Mo. State Med. Assn., Jefferson City.

April 18—Mood Disorders in Children (Children's Hospital National Medical Center and George Washington University Med. Center), Washington, D. C.

April 18-20—Scientific Assembly, W. Va. Chapter, AAFP, Morgantown.

April 19-24—Am. Academy of Pediatrics, Las Vegas.

April 20-23—W. Va. Academy of Ophthalmol. & Otolaryngol., White Sulphur Springs.

April 21-25—Am. Roentgen Ray Society, Las Vegas.

April 24-26—76th Congress on Med. Education, Chicago.

April 28-30—Southeastern Surgical Congress, Atlanta.

April 28-30—Am. Assn. for Thoracic Surgery, San Francisco.

April 28-May 2—Am. Pediatric Society, San Antonio.

April 30-May 2—Med. & Chirurgical Faculty of the State of Md., Hunt Valley, Md.

May 1-3—W. Va. Chapter, ACS, White Sulphur Springs.

May 5-8—Am. College of Obstetricians & Gynecologists, New Orleans.

May 7-10—Va. Society of Ophthalmol. & Otolaryngol., Inc., Williamsburg.

May 10-15—Ohio State Med. Assn., Cincinnati.

May 15-18—ASIM, Washington, D. C.

May 18-21—Am. Thoracic Society, Washington, D. C.

**Aug. 20-23—113th Annual Meeting, W. Va. State Assn., White Sulphur Springs.**

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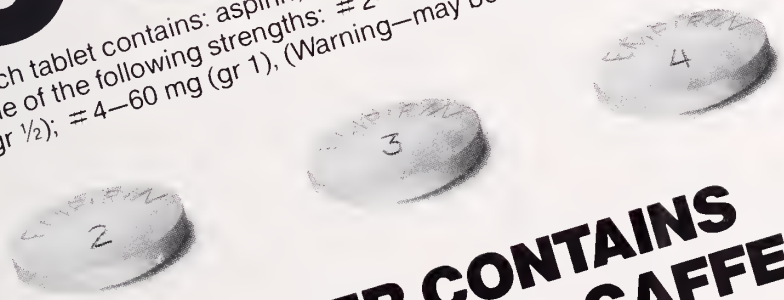


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The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

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TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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4 mg perphenazine and 10 mg amitriptyline HCl.

**CONTRAINDICATIONS:** Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

**WARNINGS:** TRiAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

**PRECAUTIONS:** Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

**Perphenazine:** Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

**Amitriptyline:** In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

**ADVERSE REACTIONS:** Similar to those reported with either constituent alone.
**Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect, hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement, hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

**Amitriptyline:** Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia, palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress; vomiting, anorexia, stomatitis; peculiar taste; diarrhea, parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue, headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

**OVERDOSAGE:** All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered. J9TR33 (DC6613215)

*For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.*

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**Ear, Nose & Throat:**
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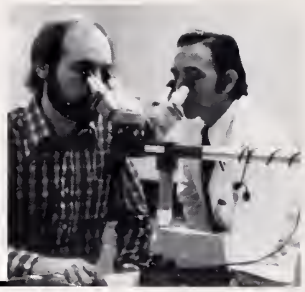
# WVU Medical Center —News—



*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## Animal Tests For Cancer Drug Encouraging

A new drug that may be effective in the treatment of cancer has been synthesized at WVU.

"It is too early to know how effective the new compound—methyl glyoxal-ascorbic acid (MG-AA)—will be," according to Gabor B. Fodor, Ph. D., D. Sc., Centennial Professor of Chemistry at WVU. "However, the results of the animal tests are encouraging and human tests are now being conducted overseas."

MG-AA was synthesized and purified at WVU under a grant from the National Foundation for Cancer Research. Testing of the drug is being done at other laboratories sponsored by the Foundation.

According to Doctor Fodor, the most general approach to treating cancer lies in developing new drugs. There are an untold number of both natural and artificial compounds that can destroy cancer cells. The rub is that they almost invariably destroy healthy cells as well.

Doctor Fodor's work at WVU involves a very special branch of chemistry—the synthesis and the elucidation of the structure of natural products. He received worldwide recognition for determining the spatial structure of cocaine, which is used as a local anesthetic in operations on the eye. Doctor Fodor has synthesized over 100 new compounds, some of which are biologically active, since coming to WVU in 1969.

"Test results thus far indicate that the growth of some cancerous tumors is arrested by treatment with MG-AA," he said. "In addition, bodily functions in general pick up after treatment. This indicates that the immune system is being stimulated.

"Thus, although we don't know the mode of action of MG-AA, it's cheap (about $1 a dose), easily made and has shown remarkable biological action for the first drug of its class."

## Heads Hospital's Emergency Surgery Service

Kevin J. Farrell, M. D., has joined the faculty as an Assistant Professor of Surgery and Chief of the newly-created Emergency Surgery Service at University Hospital.

Doctor Farrell is a graduate of the University of Pennsylvania and the Marquette University School of Medicine. He took his internship and one year of a surgical residency at Milwaukee County General Hospital before entering the Army Medical Corps, where he served for two years.

Completing his residency at the University of Arizona, Farrell spent several months as a research associate and as an attending physician on the emergency and ambulatory care services of that institution. He came to WVU from the University of Maryland in Baltimore where he was a Clinical Fellow in Trauma at the Maryland Institute for Emergency Medical Service.

## President Elect Of National Pharmacology Group

William W. Fleming, Ph. D., Chairman of Pharmacology and Toxicology, has been chosen to head the American Society for Pharmacology and Experimental Therapeutics (ASPET).

ASPET is one of the most prestigious scientific organizations in the country. It was founded in 1908 by John Jacob Abel, the father of American pharmacology.

Doctor Fleming, a member of the WVU faculty since 1960 and Chairman of the Pharmacology Department since 1966, was elected by mail ballot to take office July 1 as President-Elect, and will assume the presidency a year later. He will then serve a third year on the nine-member governing council as Past President.

"This is the highest possible recognition and an outstanding compliment from his colleagues nationwide," said John E. Jones, M. D., Dean of the School of Medicine.

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# Third-Party News, Views and Program Concerns

## Tough Ethical Questions Being Studied

Some of the toughest and most far-reaching social and philosophical questions facing medicine are on the agenda of the new Presidential Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

The 11-member commission, including six physicians, has conducted its first meeting with an imposing list of initial assignments:

The requirement for informed consent in research and medical practice; the definition of death; programs for genetic testing, counseling and education; differences in the availability of health services by income or place of residence, and the confidentiality and privacy of medical records.

Commission Chairman Morris Abram, a New York attorney, said "a thoughtful consideration of these enumerated subjects reveals an overarching concern derived from enormous strides in the natural sciences and the tensions which have resulted.

"The once-simple fact of death has been rendered murky by machines which can prolong ordinary vital functions," he noted.

"Informed consent becomes complicated when advanced therapies are difficult to explain and their results far from predictable.

"Privacy of medical care, formerly confidently assumed, is now sorely tested by the proliferation of technicians, specialists and the inevitable records and other accouterments of modern medicine and life," said Abram.

He asked if there is any way to distribute medical care wisely and fairly, not only on the basis of income and geography, but also with respect to age. "In other words, should society concentrate its always-limited medical resources to barely sustain life in the aged infirm as opposed to better care for the young?

"The hard questions are endless—but they are not academic, and the answers affect the quality of research, the quality of life, the health of the public—and the pocketbook," Abram said.

## Budget Reflects Modest Health Increases

A $60.9 billion health budget, featuring modest increase for most HHS health programs during the fiscal year starting next September, was submitted to Congress by the Administration. This is more than $5 billion above the current year's level, largely due to increases in the costs of Medicare and Medicaid.

In presenting the HHS budget at a news conference, Secretary Patricia Harris noted that President Carter's total budget "was constructed in the context of overall fiscal restraints, the necessity to curb inflation, and the requirement to meet needs made compelling by international events."

The total HHS budget came to $222.9 billion, an increase of $28 billion, with Social Security programs accounting for $152.8 billion. The Administration asked $195 million for professional standards review organizations, an increase of $51 million. PSROs are effective in reducing hospital utilization and the cost of care, the budget said.

Funding for the development of health maintenance organizations would be increased by 19 per cent, for a total of $57.4 million.

## Rules For Protecting Persons Involved In Testing

The Food and Drug Administration (FDA) recently established rules to protect human subjects involved in testing medical devices for safety and effectiveness.

The rules place the primary responsibility for protecting the subjects on the device's manufacturer, the person conducting the investigation (usually a physician), and the local review boards in hospitals and universities where such tests are conducted.

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S. O. Chung, M. D.
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M. C. Rosenberg, D. O. (Helvetia Clinic)
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P. M. Tanna, M. D. (Green Bank Clinic)
J. H. Truitt, M. D. (Marlinton Clinic)

**EMERGENCY MEDICINE:**
R. H. Plummer, D. O.
A. M. Fuller, M. D.
F. A. Khan, M. D.

**FAMILY PRACTICE:**
L. H. Valliant, M. D.
H. E. W. Gregor, M. D.

**INTERNAL MEDICINE:**
**Gastroenterology:**
S. S. Masilamani, M. D.
**Allergy & Rheumatology:**
J. B. Magee, M. D.
**Cardiology:**
H. L. Jellinek, M. D.
P. W. Gregor, M. D.
**Metabolic & Endocrine Diseases:**
F. Becerra, M. D.
**Pulmonary Diseases:**
J. C. Arnett, Jr., M. D.

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H. H. Cook, Jr., M. D.
J. F. de Courten, M. D.
J. J. Rizzo, M. D.

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D. R. Antonio, M. D.

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M. M. Stump, M. D.

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Y. J. Kwon, M. D.
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F. H. Abdalla, M. D.
H. Y. Mang, M. D.

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W. B. Blum, M. D.
B. R. Blackburn, M. D.

**UROLOGY:**
D. T. Chua, M. D.

# Obituaries

## EDWIN A. TRINKLE, M. D.

Dr. Edwin A. Trinkle of Weston, a former member of the State Medical Association's Council, died on January 20 in a Morgantown hospital. He was 76.

A general practitioner and surgeon, Doctor Trinkle began practice in Weston in 1931. He was a native of Hardinsburg, Indiana.

Doctor Trinkle was graduated from the University of Louisville and received his M. D. degree in 1930 from that institution's School of Medicine. He interned at Ohio Valley General Hospital in Wheeling.

Doctor Trinkle was a board member of Stonewall Jackson Memorial Hospital in Weston.

He was an honorary member of the Central West Virginia Medical Society, of which he was a former Secretary; the West Virginia State Medical Association and American Medical Association.

Surviving are the widow and two daughters, Mrs. Joan Keener of Huntington and Dr. Sarabeth Walker of Wilmington, Delaware.

* * *

## STEPHEN MAMICK, M. D.

Dr. Stephen Mamick of White Sulphur Springs, retired radiologist, died on January 23 in a Fairlea hospital. He was 68.

Doctor Mamick practiced in White Sulphur Springs from 1939 to 1951, and later in Mingo and McDowell counties. He was on the staff of Stevens Clinic Hospital in Welch at the time of his retirement in June, 1979.

He was a former Secretary of the Mingo County Medical Society and a Past President of the McDowell County Medical Society.

A native of Benwood, Marshall County, he was graduated from West Virginia Wesleyan College, receiving a B. S. degree in Medicine from West Virginia University and an M. D. degree in 1938 from Rush Medical College in Chicago.

Doctor Mamick interned at St. Francis Hospital in Pittsburgh, and completed residencies and postgraduate work at North Carolina Baptist Hospital, Winston-Salem; the Armed Forces Institute of Pathology in Washington, D. C.; St. Luke's Hospital, Chicago, and Cleveland Clinic.

He was a member of the Greenbrier Valley Medical Society, West Virginia State Medical As-

(Continued on next Page)



**Tenuate® ⓒ**
(diethylpropion hydrochloride NF)

**Tenuate Dospan™**
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

**INDICATION** Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS** Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

**WARNINGS** If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect, rather the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children* Tenuate is not recommended for use in children under 12 years of age.

**PRECAUTIONS** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

**ADVERSE REACTIONS** *Cardiovascular* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic* Urticaria, rash, ecchymosis, erythema. *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSAGE AND ADMINISTRATION** Tenuate (diethylpropion hydrochloride) One 25 mg tablet three times daily one hour before meals and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release One 75 mg tablet daily swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSAGE** Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc
Cayey Puerto Rico 00633

*Direct Medical Inquiries to*
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Division of Richardson-Merrell Inc
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**References** 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M T, O'Dillon [Dillon], R H, and Leyland, H M A comprehensive review of diethylpropion hydrochloride In, Central Mechanisms of Anorectic Drugs, S Garattini and R Samanin, Ed New York Raven Press, 1978, pp 391-404

**Merrell**

9 4672 (Y957A)

# Overweight may not always be simple... complications can develop.*

# Complicated or not...

# Tenuate® Dospan® ℂ IV

## (diethylpropion hydrochloride NF)

**75 mg. controlled-release tablets**

### A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

### In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

### Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

## Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

# Merrell

For prescribing information see opposite page.

# A well-tolerated, nonnarcotic prescription for pain

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# Motrin® now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

| Time after drug administration (hour) | | .5 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|
| Mean relief-of-pain scores* (No. patients reporting) | Motrin 400 mg ibuprofen | .89 (108) | 1.25 (108) | 1.36 (108) | 1.28 (107) | 1.19 (106) |
| | Darvon 65 mg propoxyphene | .66 (100) | .99 (99) | 1.13 (96) | .99 (96) | .80 (96) |
| Statistical significance | | $p<0.02$ | $p<0.01$ | $p<0.05$ | $p<0.02$ | $p<0.002$ |

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

# Motrin 400 mg TABLETS
## ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

# Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

**Motrin® Tablets** (ibuprofen, Upjohn)

**Indications and Usage:** Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin.* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

**Adverse Reactions**

***Incidence greater than 1%***

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

***Incidence less than 1 in 100***

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

***Causal relationship unknown***

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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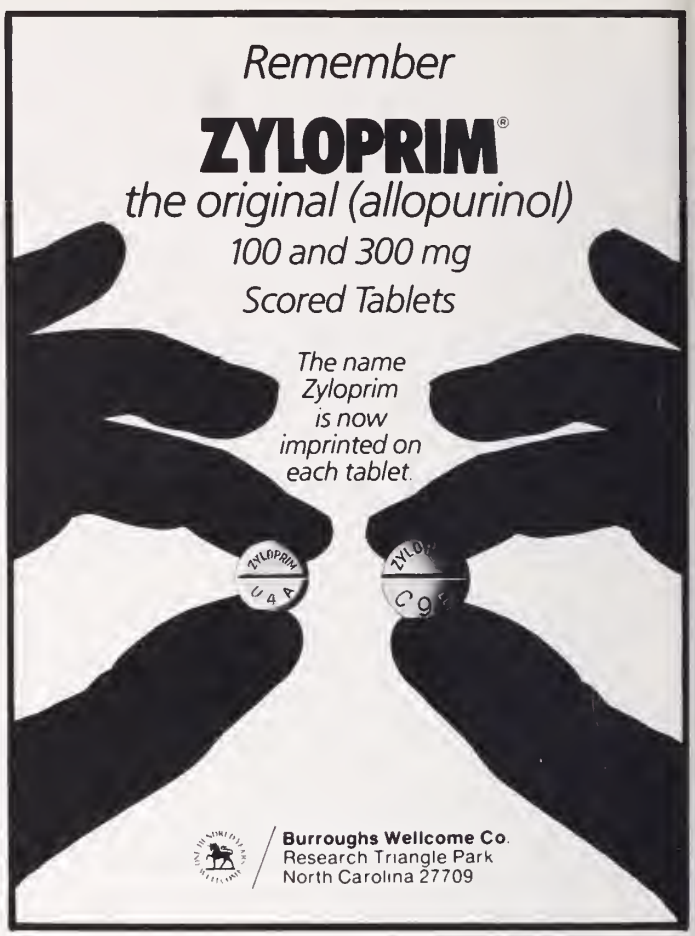

# County Societies

## CABELL

Dr. David Charles, Professor and Chairman of the Department of Obstetrics and Gynecology at Marshall University School of Medicine, was the speaker for the meeting of the Cabell County Medical Society on January 10.

The Society met at the Gateway Motel in Barboursville.

Doctor Charles presented a brief and entertaining discussion of the "Paradox of Genius."

Dr. Charles E. Turner notified the membership that the proposed new West Virginia State Medical Practice Act had been sent to the Society and that copies could be made available.—Charles E. Turner, M. D., Secretary.

* * *

## MINGO

The Mingo County Medical Society met on January 9.

Dr. David K. Heydinger, Associate Dean for Academic and Clinical Affairs for Marshall University School of Medicine, was the guest speaker.

Doctor Heydinger presented plans for the community-oriented residency program of the Medical School. The long-term program is aimed at the training and retaining of physicians in West Virginia, he said.

Dr. Arthur E. Levy of Williamson, our Councilor to the State Medical Association's Council, reviewed the recent actions of that body.

Dr. Stephen D. Ward of Wheeling, President of the State Medical Association, addressed the annual Ladies Night Christmas meeting of the Society.—Arthur E. Levy, M. D.

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*OBITUARIES—Continued*

sociation, American Medical Association, Southern Medical Association, Radiological Society of North America, American Society of Clinical Pathology, Aerospace Medical Association, West Virginia Heart Association, Civil Aviation Medical Association, and the American Association of Chest Physicians. He also was a Fellow of the International College of Surgeons.

Doctor Mamick was a veteran of World War II.

Surviving are the widow and a sister, Mrs. Ann Hummel of Benwood.


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**Gynecology and Obstetrics:**
Raymond W. Cronlund, M. D.

**Internal Medicine:**
E. G. Guy, M. D.
Karl J. Myers, Jr., M. D.
Wm. A. SanPablo, M. D.
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# Book Review

**UNDERSTANDING HYSTERECTOMY: A WOMAN'S GUIDE**—F. G. Giustini, M. D.; and F. J. Keefer, M. D. (Introduction by Elizabeth B. Connell, M. D.). 166 pages. Price $7.95 (paper). Walker and Company, 720 Fifth Avenue, New York, New York 10019. 1979.

This book has been written in the interest of "every woman who has had a hysterectomy or may some day be advised to have one" (see back cover), partly to exonerate the authors from the failure of gynecological surgeons to make an "attempt to illustrate clearly for our patients the status of this very common procedure." It is more appropriately addressed to the prospective hysterectomy patient with the hope that the contents of this book will help her to arrive at an "intelligent and informed decision."

The book has a few weaknesses. The authors are compelled to define medical terms, at times repeatedly, despite the inclusion of a glossary. Some definitions are not entirely accurate, such as those given for "speculum" and "fistula".

A few errors are intolerable. A lymph node is never a "gland" and the ovaries are not "attached to the back surface of the uterus on each side." Carcinoma *in situ* and invasive carcinoma are stages, not types, of cancer.

An occasional statement appears ambiguous. "A doctor is a doctor, no matter what the specialty" was probably meant to read, "A *medical* doctor . . .," for there are all sorts of doctors!

Lapses into taken-for-granted medical jargon, e.g., "surgical field" and "postop", are rare.

The book may not be too concise nor simple for the woman whom the authors are trying to reach. The woman who faces the prospect of a hysterectomy might be helped better with pamphlets and brochures with illustrations or diagrams, pictures or posters and with audio-visual aids dealing with the proposed surgical procedure. These could reinforce, amplify and/or clarify what information she has already received from the surgeon.

This book could make for leisurely and enjoyable reading by the privileged woman—one blessed with a good education, good health, financial and emotional security and with plenty of time on her hands. Conceivably it could be a useful resource material for leaders of women's groups and clubs and for school teachers. It would be of great benefit to nurses, physicians' assistants, social workers and other para-medical personnel. In it they may find answers to questions which haunt hysterectomy patients, questions which they should have asked their surgeons but never dared to do.—Josefina M. Orteza, M. D.


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**General Practice/Family Practice/Internist**—We are currently recruiting for placement in our clinics (four) for July 1, 1980 openings. We are located in rural southern West Virginia and have an excellent statewide reputation. Salaries are negotiable and benefits include paid vacation, study leave, malpractice insurance, moving expenses. Also available are tax sheltered annuities and pension plan. We are seeking physicians who would like to grow with our system and are willing to accept responsibility for practice development. If you think you may be interested, please contact Hygeia Facilities Foundation, P. O. Box 217, Whitesville, West Virginia 25209, Attn.: Administrator.

## OPPORTUNITY AVAILABLE

Senior Physician for Center for the Mentally Retarded. Supervises the delivery of quality medical services for 900 retarded children and adults. Duties include supervision of seven physicians, consultation and professional liaison with other service providers. Must be licensed to practice in Virginia. Salary range $33,400-$51,700, liberal state benefits, good working environment.

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**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician for 9 year old modern 80 bed hospital centrally located between Parkersburg and Charleston. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

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**WANTED**—A physician for the twin towns of Harpers Ferry and Bolivar, West Virginia—about 8 miles from Charles Town, where there is a hospital. Serving a population of 1500. Twin towns located in scenic mountain area, good fishing and Harpers Ferry National Park—approximately 1½ hours' drive from Washington, D. C. Contact Mr. Reid V. Geronimo, President Bolivar Civic Association, Route 1, Box 5, Harpers Ferry, WV 25425. Telephone: (304) 535-6528.

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**Before prescribing, please consult complete product information, a summary of which follows:**

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**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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# The West Virginia Medical Journal

*Official Publication of the West Virginia State Medical Association*

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# CONTENTS

**Scientific Articles**

Laryngocele: A Review of the Literature and Case Report — J. Harden Howell III, M. D.; Philip M. Sprinkle, M. D.; and F. T. Sporck, M. D. 75

Mass Lesions of the Neck—Halifax C. King, M. D. 81

An Architect Designs A Needle—John C. Krantz, Jr., Ph.D. 84

**Special Article**

Good Chances for Good Changes: Rehabilitation in West Virginia—Leslie F. McCoy, M. D. 86

**The President's Page**

A Louder Voice—Betty (Mrs. D. Sheffer) Clark, President, Auxiliary to the W. Va. State Medical Association 90

**Editorials**

Tax Worries 91

Change in Attitude 91

FTC Setbacks 92

**General News**

AMA President Annual Meeting Speaker 93

Legislature Approves Association Program 94

Review A Book 94

Continuing Education Activities 95

Wildwater Surgical Conference June 7 95

Wheeling Endocrine, Breast Surgery Program 96

State Pediatricians to Meet in April 96

Anesthesiologists Plan June Meeting 97

**Special Departments**

WVU Medical Center News xii

Third-Party News, Views, Program Concerns xiv

Obituaries xvi

County Societies xvii

Classified Section xx

Index To Advertisers xxii

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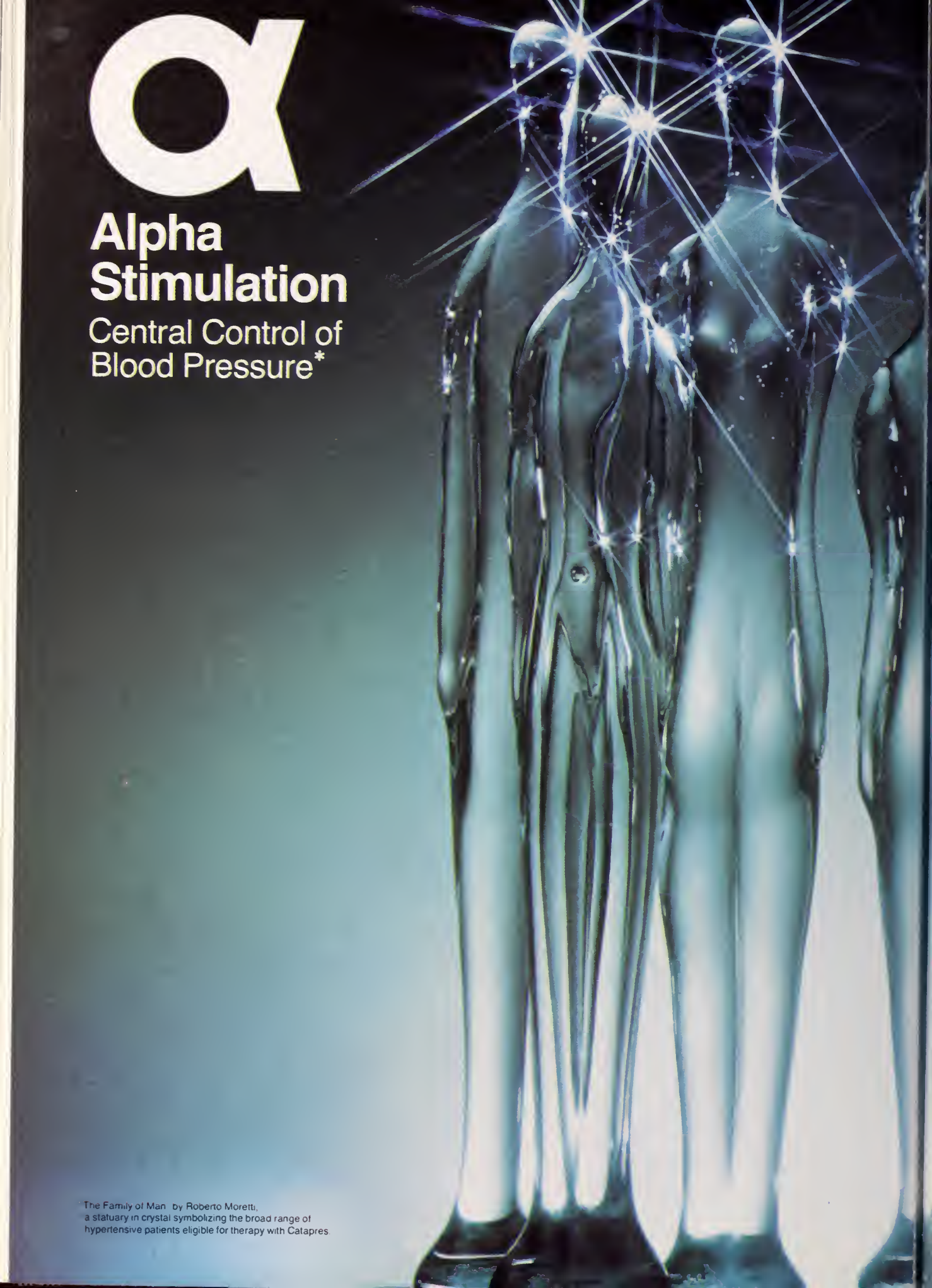
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1 Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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# Hypertension

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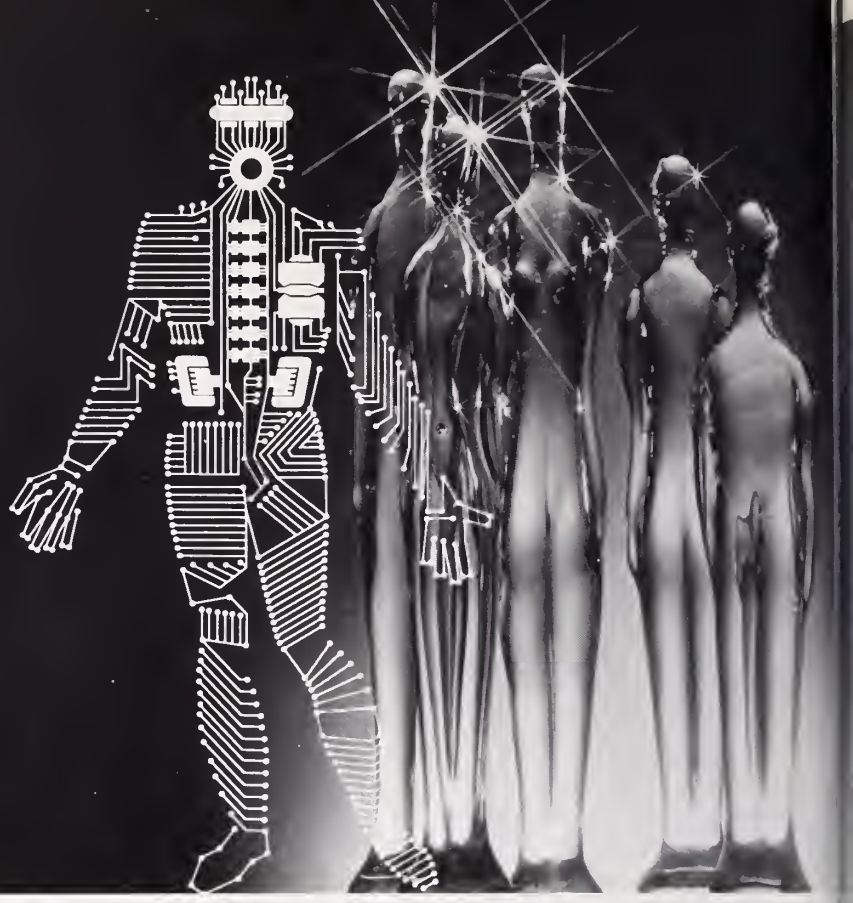

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# Catapres®

## (clonidine HCl)

# Hypertension

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- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

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Maximum daily dose—2.4 mg
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---

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*Usage in Pregnancy:* In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
*Usage in Children:* No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

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**Adverse Reactions:** The most common reactions are dry mouth, drowsiness a sedation. Constipation, dizziness, headache, and fatigue have been report Generally these effects tend to diminish with continued therapy. The follow reactions have been associated with the drug, some of them rarely. (In so instances an exact causal relationship has not been established.) These inclu Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalitie liver function tests; one report of possible drug-induced hepatitis without icte and hyperbilirubinemia in a patient receiving clonidine hydrochloride, ch thalidone and papaverine hydrochloride. Weight gain, transient elevation of blo glucose, or serum creatine phosphokinase; congestive heart failure, Raynau phenomenon; vivid dreams or nightmares, insomnia, other behavioral chang nervousness, restlessness, anxiety and mental depression. Also rash, gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associa with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryne itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomas weakly positive Coombs' test, asymptomatic electrocardiographic abnormalit manifested as Wenckebach period or ventricular trigeminy.

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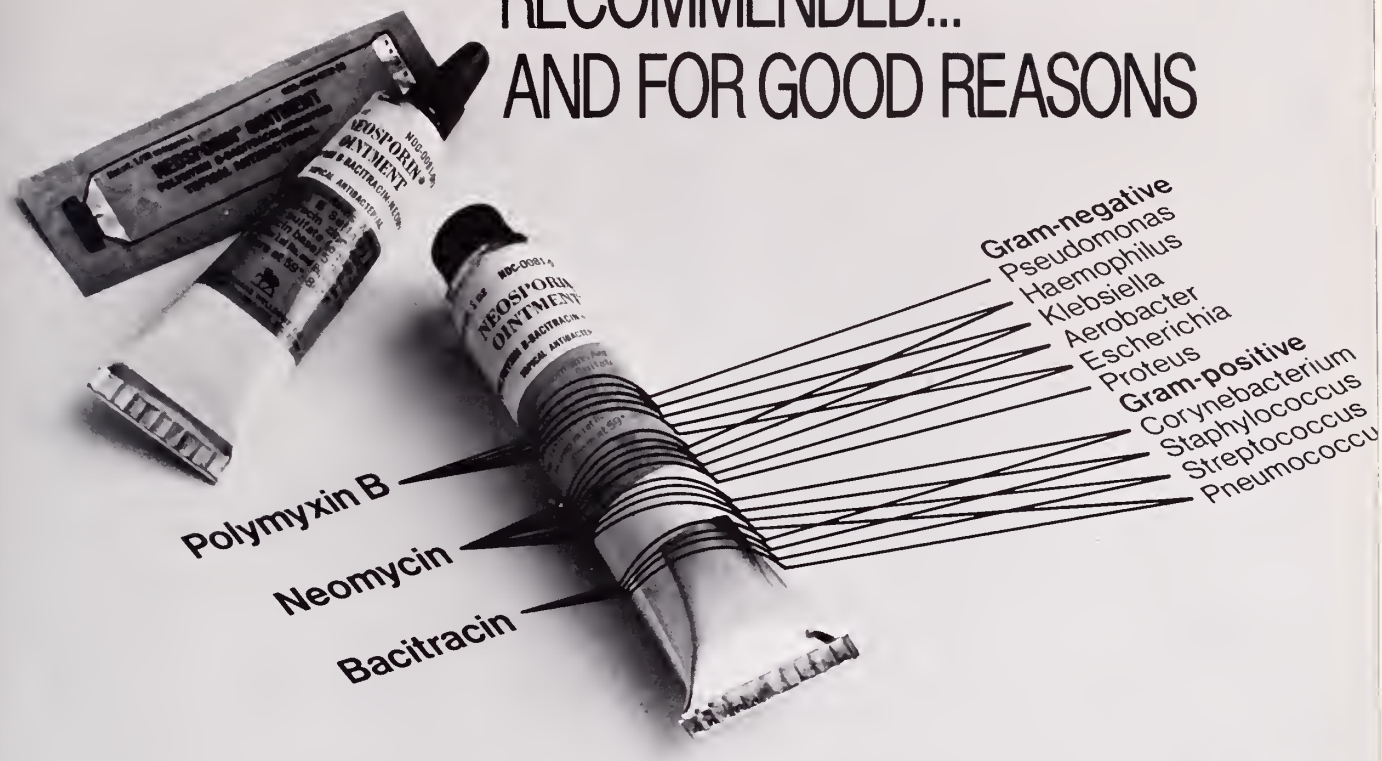


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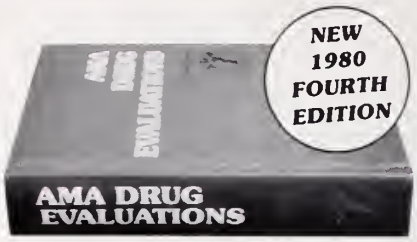


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The West Virginia Medical Journal

Vol. 76, No. 4 April, 1980

# Laryngocele: A Review Of The Literature And Case Report

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*A laryngocele is an abnormal cystic dilatation of the saccule of the larynx. The sac may be limited to the endolarynx, may present as an extralaryngeal mass, or as a combination of both types. Symptoms result from the mass effect of the dilated sac in the larynx and neck. Diagnosis is made on the basis of a history of intermittent neck swelling particularly associated with valsalva maneuvers. Radiologic studies confirm the diagnosis. The potential for airway obstruction exists, and, therefore, surgical removal is advocated when a laryngocele is diagnosed. This article presents a review of the literature and a case report of a combined laryngocele treated at West Virginia University Medical Center.*

The laryngeal ventricle was first described in 300 A. D. by Galen; however, a detailed anatomical description awaited the work of Morgani. His work in 1741 resulted in the structure being named for him. In 1837, Hilton wrote a detailed description of the sacculus, or appendix of the ventricle. The term "laryngocele" was introduced by Virchow in 1867 to refer to saccular dilatations arising from the ventricle.[1,2]

The first clinical description of laryngoceles was by Larrey in 1829. He was a surgeon in Napoleon's army of occupation in Egypt, and observed neck masses in the men who read prayers from the minarets. These masses were air-filled cysts which would increase in size until a firm collar was required to support the neck. Finally, the crier would become hoarse and then aphonic. He would then be reduced to menial jobs on the temple grounds.[1,3]

### Normal Anatomy

The laryngeal ventricle is formed embryologically by the splitting of the common thyroarytenoid sphincter into a lower segment, the true cord, and an upper segment, the future false cord.[3] The ventricle is thus a horizontal recess bordered above by the false cord and below by the true cord. Fibers of the thyroarytenoideus muscle and the thyroid cartilage form the lateral wall.[4] The ventricle is entered by a slit-like aperture just superior to the true cord.[5]

The saccule is an elognated diverticulum arising from a tiny orifice located in the anterior of the ventricle. It rises vertically into a pocket between the thyroid cartilage and the base of the epiglottis. The saccule measures approximately eight mm. in length. [4,5,6] The thyroepiglottic and aryepiglottic muscles sweep around the upper part of the sac into the aryepiglottic fold. [6]

The saccule is present by the eighth week of fetal life. It is relatively large at birth, and seems to regress in the first six years of life. The ventricle continues to grow, becoming a deeper cavity.[3]

Histologically, the saccule is lined with ciliated, pseudo-stratified columnar epithelium. The submuscosal layer contains both lymphatic elements similar to adenoid tissue and tubular glands. The glands contain both mucous and serous secreting cells.[3,4,5] Hilton theorized that the secretions of the saccular glands are express-

ed by compression from the surrounding muscles and serve to lubricate the vocal cords.[6]

The human laryngeal saccule is reminiscent of the air sacs found in some primates, particularly the orangutan. These animals have air sacs extending into the neck and over the chest. They are thought to perform some function during phonation and to serve as an air reservoir when the animal climbs.[7]

### Etiology of Laryngoceles

By definition, a laryngocele is a cystic dilation of the sacculus. The common denominator in development of a laryngocele is increased intralaryngeal pressure. During exertion, the true cords fail to remain completely approximated, while the sphincteric action of the muscles surrounding the upper larynx (thyroarytenoid, thyroepiglottic and aryepiglottic) keeps the false cords competent. Increased intralaryngeal pressure results.[6]

Strenuous expiratory effort as in glass blowing, singing, or playing a wind instrument historically has been associated with development of laryngoceles.[4,8] More recent studies, however, indicate that strenuous muscular exertion, as in lifting, pulling, straining at defecation, or straining with childbirth, causes a greater increase in pressure at the ventricular level than does blowing.[1,6]

Other factors may contribute to development of a laryngocele. Von Hippel theorized a congenital abnormal development of the saccule such that its orientation predisposed to laryngocele formation.[4] A valve-like mechanism allowing air to enter the saccule but preventing its escape has also been postulated. Decreased tissue tone in older patients may also permit abnormal dilatation of the saccule.[3,8]

Several patients with laryngoceles have been reported whose only contributing factors were age and a history of chronic bronchitis with a productive cough for several years. These have been smokers with 20 or more pack-years.[7,10]

### Classification

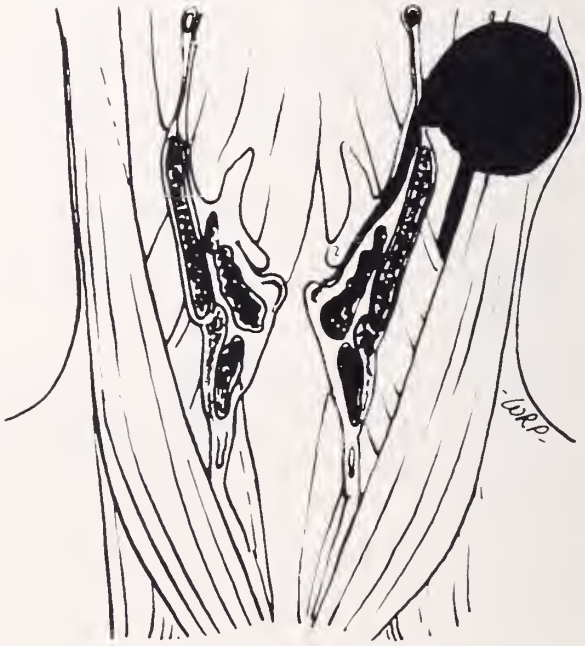
Three types of laryngoceles are described: External, internal and combined. The classification depends on the relationship of the sac to the thyrohoid membrane.[3,4,5] DeRosario reported the relative incidence as 70 per cent internal, 25 per cent external and five per cent combined.[1]

*External Laryngocele (Figure 1).* The dilated saccule of the external laryngocele extends along the inner surface of the thyroid cartilage. It perforates the thyrohyoid membrane, usually at the site of perforation of the neurovascular bundle. It then appears as a mass in the submandibular area at approximately the level of the hyoid bone.[4,7]

The patient presents with a soft neck mass which may cause some local discomfort. Headache may be produced secondary to venous compression. Classically, the patient notes increase in the size of the mass associated with coughing, straining or sneezing. He denies change in his voice, but may admit mild dysphagia. If the laryngocele has been infected, he may complain of foul breath or a bad taste.[3,4,9,10]

On examination, a soft, elastic mass is present beneath the soft tissues of the neck at approximately the level of the hyoid bone. Pressure usually reduces the mass, often with a simultaneous hissing sound as air escapes into the larynx. Indirect laryngoscopy is normal. A-P soft tissue x-ray of the neck will demonstrate a sharply defined radiolucent area superimposed on the neck muscles.[3,4,5]

Treatment is surgical. The laryngocele is approached via a transverse incision in the neck just inferior to the hyoid bone and just above the thyroid cartilage. Blunt dissection is used to identify the outer wall of the laryngocele. Dissection is then carried down along the wall to the pedicle. The superior laryngeal nerve and vessels are identified and spared. The laryngocele



EXTERNAL LARYNGOCELE

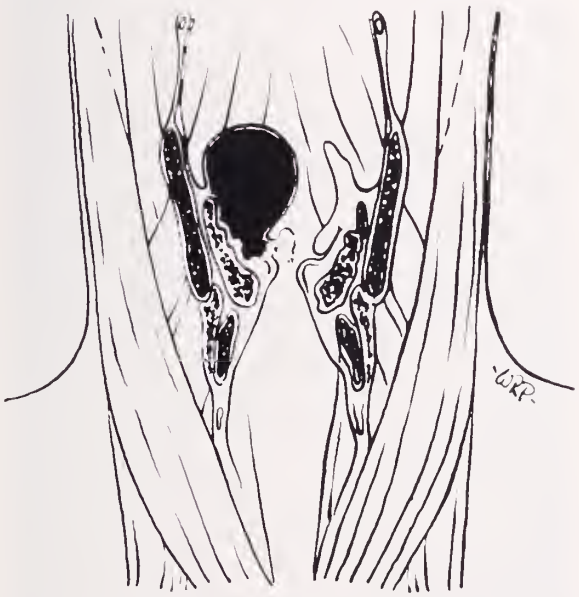
**Figure 1.**

pedicle is ligated at the thyrohyoid membrane. The laryngocele is amputated and the stump allowed to drop behind the thyrohyoid membrane. A layer closure is used.[4]

*Internal Laryngocele* (*Figure* 2). The internal laryngocele consists of the dilated saccule extending upward into the aryepiglottic fold.[11] The patient presents with complaints of hoarseness, often intermittent and with varying degrees of severity. He may describe symptoms of respiratory obstruction. One may note a belch-like sound before the beginning of speech. This is produced by constriction of the pharyngeal muscles expressing air from the laryngocele.[3,5,8]

The external examination of the neck is normal. Indirect laryngoscopy reveals a protruding, mucus-covered mass which covers the true cord, pushes the false cord anteriorly, and may extend across the midline. A lateral neck film will show the radiolucent area overlying the vallecula, epiglottis, and larynx. Polytomography will further define the mass. Post-dye injection radiology has been described, but is not necessary and may be hazardous. The diagnosis is confirmed at direct laryngoscopy when aspiration returns air and reduces the mass.[4,5,8,10]

An internal laryngocele may obstruct the airway at any time by suddenly enlarging during a Valsalva or by becoming infected and swollen. Therefore, even asymptomatic, internal laryngoceles should be treated. Conservative treatment has been tried, including injection of sclerosing agents and endoscopic resection with or without fulguration. The complications and frequency or recurrence do not justify these methods. An external surgical approach is now advocated.[4,6,9,12]



INTERNAL LARYNGOCELE

**Figure 2.**

Various external surgical approaches have been described. The best approach probably consists of going through a horizontal incision in a flexion crease over the thyrohyoid membrane, very much like the incision used in approaching the external laryngocele. The thyrohyoid membrane is exposed and incised bluntly. It may be necessary to excise the posterior third of the thyroid cartilage to gain exposure. However, cutting a notch in the superior border of the thyroid cartilage may allow dissection to the neck of the laryngocele. Some authors include splitting of hyoid bone to improve exposure. The laryngocele is dissected bluntly, ligated at its neck, and excised. The stump is inverted and closed with a purse-string suture.[5,8,15]

The larynx need not be entered if the above technique is used. Again, the superior laryngeal nerve and vessels must be preserved. Tracheostomy is frequently advisable.[3,5,8,13]

Laryngofissure techniques have been described; however, this may result in excessive intralaryngeal scarring with consequent voice impairment and possible laryngeal stenosis.[5]

*Combined Laryngocele.* The combined laryngocele consists of both the external dilatation and the internal sac communicating through the thyrohyoid membrane. Symptoms and findings include any or all of those described for the isolated internal or external laryngocele. A unique finding is that pressure over the external mass may increase the size of the internal mass as seen directly or indirectly.[4,6]

Treatment is again surgical via the external approach described above. A finger placed in the lumen of the external component may be used to guide dissection of the internal component and further decrease the chance of entering the pharynx or damaging the vocal cords.[4,6]

**Presentation of Case**

M. P., a 52-year-old white female, was first admitted to the ENT service at West Virginia University Medical Center in February, 1976. She was referred for evaluation of intermittent hoarseness of six-months' duration. She also noted some increase in her usual dyspnea. She had approximately a 35 pack-year smoking history. Her past history revealed mild, chronic, obstructive pulmonary disease for which she was taking bronchodilators.

Physical examination revealed a thin, chronically-ill-appearing, white female. Two mobile left anterior cervical nodes and one right cervical node were present in the neck. Lungs revealed bilateral scattered ronchi, consistent with COPD which was later confirmed by pulmonary function tests showing a moderate irreversible obstruction defect. Admitting chest x-ray was consistent with COPD and also revealed a calcified granuloma in the left upper lung field. The general physical examination and routine laboratory results were otherwise normal.

Indirect laryngoscopy revealed a lesion in the left vallecula. The larynx appeared normal except for some fullness of the right false cord. Laryngogram revealed a four-cm. collection of air initially felt to be located laterally in the hypopharynx (Figure 3). The epiglottis and supraglottic larynx were displaced to the right.

The patient underwent panendoscopy on February 2, 1976. A left vallecular lesion was biopsied. The vocal cords were noted to have polypoid changes. The left false cord appeared full. The remaining tracheo-bronchial tree and esophagus were normal. Random biopsies were taken from the nasopharynx and left tonsil. The pathological diagnosis of the left vallecular lesion was capillary hemangioma. The nasopharyngeal and tonsil biopsies had no diagnostic abnormalities.

**Figure 3. Laryngogram demonstrating left laryngocele.**

Laryngeal tomograms were obtained on February 27, 1976. They revealed a large air-containing pouch at the level of the left pyriform

**Figure 4. A-P tomogram showing left laryngocele. Note connection between cyst and intralaryngeal air column.**

**Figure 5. Xeroradiograph of neck with left laryngocele.**

sinus. The false cords were felt to be normal (Figure 4). Our diagnosis was external laryngocele. A xero-radiograph of the neck also demonstrated the lesion (Figure 5).

The patient developed fever and increased sputum production. She was therefore treated with appropriate antibiotics. Her symptons improved and the cervical adenopathy resolved. She declined surgery for her laryngocele and was discharged.

She was followed in clinic and remained hoarse. She also continued smoking. By July, 1976, a large, soft mass was present in her left neck, anterior to the sternocleidomastoid muscle. Following compression of the mass, she could re-expand it with a Valsalva maneuver. Indirect examination at this time revealed definite bulging of the left false cord. We now felt she had a combined laryngocele.

By October, 1976, she presented complaining of increasing dyspnea and dysphagia. Indirect laryngoscopy revealed a mass involving the left aryepiglottic fold. The left neck mass was hard, tender, and not reducible. She was started on antibiotics and admitted three days later. On admission, the left neck mass was again soft and compressible. She related a history of suddenly coughing a large amount of thick sputum, after which her symptoms improved and her mass had become soft. We assumed her laryngocele had become infected and spontaneously drained.

**Figure 6. Left combined laryngocele as seen in A-P soft tissue x-ray of neck.**

An A-P soft tissue x-ray of the neck revealed a collection of air on the left consistent with a combined laryngocele (Figure 6). Repeat laryngogram was unchanged from February, 1976. Direct laryngoscopy again revealed the hemangioma in the left vallecula, confirmed by repeat biopsy. The left aryepiglottic fold was normal at the time of the examination. Bilateral vocal cord hydrops was present.

### Tracheostomy Performed

The patient was now sufficiently impressed by her intermittent symptoms to accept surgery. On November 1, 1976, a tracheostomy was performed under local anesthesia. General anesthesia was then induced. The laryngocele was approached through a collar incision extending from the midline to the left anterior sternocleidomastoid muscle. The laryngocele sac was identified and dissected free. It pierced the thyrohyoid membrane with the superior laryngeal neurovascular bundle. The dissection was carried over the top of the thyroid cartilage and the internal component of the laryngocele identified. The external sac was entered and, with gentle traction, the internal component was dissected free from the thyroid cartilage and from the hyoid bone above. The sac terminated in a small isthmus. It was ligated here and the sac excised. The wound was closed in layers.

While still under general anesthesia, direct laryngoscopy was performed with stripping of the left vocal cord and biopsy of the right cord. Pathology reports revealed the laryngocele sac to be lined with pseudostratified columnar epithelium. The left vocal cord showed papillary hyperplasia and the right vocal cord had focal epithelial hyperplasia.

The postoperative course was uneventful. She was decannulated and then discharged.

The patient was readmitted December 15, 1976, and underwent direct laryngoscopy with stripping of the right vocal cord. There was no evidence of recurrent laryngocele. The pathology report was again focal epithelial hyperplasia.

The patient has subsequently been seen in clinic. Her voice is improved but she remains hoarse. Examination and indirect laryngoscopy on January 4, 1977, showed nothing to suggest laryngocele recurrence. She continues to smoke.

### Discussion

Laryngoceles were once thought to be more rare than they probably are. In 1966, over 200 cases had been reported, but 150 of these had been reported in the previous 10 years,[8] sug-

gesting an increase in physician awareness. The lesion occurs more commonly in males with a 3:2 male-female ratio.[1] Most patients are over 50,[8] but laryngoceles have been found in children from two months old to 13 years old.[14,15] The incidence is increased in musicians playing wind instruments. Macfie reported a 56 per cent incidence in a series of wind instrument bandsmen.[16] In another radiological study of 100 cases of patients with chronic cough, 20 had x-ray evidence of laryngocele.[17]

Laryngoceles have been reported to be associated with carcinoma of the larynx. Pietrantoni reported 53 laryngoceles in 1,000 patients undergoing laryngectomy for carcinoma.[13] Meda reported six laryngoceles in 650 cases of cancer of the larynx.[19] An association with cancer of the larynx is reasonable, as smoking is carcinogenic and also produces a chronic cough syndrome, hence predisposing to laryngocele formation.

The most dangerous complication of a laryngocele is airway obstruction. Infection, both acute and chronic, also occurs rarely. When a laryngocele does become infected, it may cause obstruction and asphyxia.[2,4,6,8] An infected laryngocele may also rupture into the lateral pharyngeal space and produce infection there. Aspiration of purulent material from an infected laryngocele can cause bronchitis and pneumonia.[7] One should also beware of capricious demonstration of a patient's ability to expand his laryngocele. Four deaths have been reported in x-ray departments due to acute airway obstruction following Valsalva maneuvers.[8]

It is our feeling that all internal and combined laryngoceles should be surgically removed. An asymptomatic external laryngocele may be followed; however, all external laryngoceles must have an internal component even though it is not dilated. Hence, they may be reasonably predicted eventually to become combined and require treatment.

**References**


1. Wright LD Jr, Magunda LA: Laryngocele: Case report and review of the literature. *The Laryngoscope* 74: 396-412, 1964.

2. Lhawley SE, Bone RC: Laryngopyocele. *Laryngoscope* 83: 362-368, 1973.

3. Lane SL, Cohen B, Ippolito C: Coexisting Internal and External Laryngoceles. *Am J Surg* 96: 810-814, 1958.

4. Richards L: Laryngocele. *Ann of Otol, Rhinol & Laryngol* 60: 510-522, 1951.

5. Kein WF, Livingstone RG: Internal Laryngocele. *Ann of Otol Rhinol & Laryngol* 60: 39-50, 1951.

6. Fredrickson JM, Ward PH: Laryngocele Ventricularis. *Archives of Otolaryngol* 76: 568-573, 1962.

7. English GM, DeBlanc GB: Laryngocele: A case presenting with acute airway obstruction. *The Laryngoscope* 78: 386-395, 1968.

8. Yarington CT, Frazer JP: The surgical treatment of laryngocele. *Surg, Gynecol & Obstet* 122: 308-312, 1951.

9. Holinger PH *et al.*: Congenital Anomalies of the Larynx. *Ann of Otolaryngol* 63: 581-605, 1954.

10. Ward PH *et al.*: Laryngeal and Pharyngeal Pouches. *The Laryngoscope* 73: 564-582, 1963.

11. Lober P: Histology and pathology of the thorax, larynx, esophagus and tracheobronchial tree, in Paparella and Shumrick: *Otolaryngology,* vol 1, p 573, 1973.

12. Putney FJ: Laryngocele. *Laryngoscope* 78: 749-755, 1968.

13. O'Keefe JJ: The surgical treatment of laryngocele. *Ann of Otol, Rhinol, & Laryngol* 61: 1071-1075, 1952.

14. Schall LA: Laryngocele—Associated with cancer of the larynx. *Ann of Otol, Rhinol, & Laryngol* 53: 268-173, 1944.

15. Walpita RP: Laryngocele in an infant. *J of Pediatric Surg* 10: 843-844, 1975.

16. Macfie DD: Asymptomatic laryngoceles in wind instrument bandsmen. *Arch of Otolaryngol* 83: 270-275, 1966.

17. Felisati DD *et al.*: (quoted in Ward and Fredrickson, reference 6 above).

18. Pietrantoni L, Felisati D, Finzi A: Laryngocele and laryngeal cancer. *Ann of Otol, Rhinol & Laryngol* 68: 100-107, 1959.

19. Meda P: Symptomatic Laryngocele in Cancer of the larynx. *Arch of Otolaryngol* 56: 512-520, 1952.

# Mass Lesions Of The Neck

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*An orderly approach to the management of neck masses is essential. This is a long-standing sentiment of most surgeons, especially in head and neck surgery. Forty-eight cases of neck masses seen over an eight-year period at the Ohio Valley Medical Center are presented and analyzed.*

THE proper approach to the evaluation and management of mass lesions of the neck is a subject of continuing concern to all surgeons. Since the often-quoted writings of Dr. Hays Martin in the early 1950s, the premature biopsy by excision of cervical tumors persists as a problem which needs periodic attention.[1] It has long been recognized that any middle-aged or older person presenting with a lateral mass lesion of the neck is almost certainly manifesting metastatic malignant disease. Nevertheless, Bridger and Reay-Young[2] reported in July, 1978, that 70 per cent of patients referred to the Head and Neck Oncology Unit of their hospital in Sydney, Australia, already had the mass incised or excised. In another report by Davis[3] in Florida, testimony is given of inappropriate evaluation and management of the neck tumor.

Davis has amply reviewed the protocol for evaluating the patient who presents with a neck mass. A good history and physical examination is the first step. Since neck masses often represent spread of cancer from the upper air and food passages, panendoscopy (naso-pharyngoscopy, direct laryngoscopy, esophagoscopy, and bronchoscopy) is a crucial part of the patient's examination. A chest x-ray and pertinent laboratory data are ordered. If the work-up must be carried further, then laryngogram, soft tissue films of the neck and sinuses, lung tomograms, upper and lower G. I. series and an intravenous pyelogram may be obtained. Further studies may include thyroid and salivary gland scans and sialograms.

### Panendoscopy Repeated

Should all of the above studies fail to show the primary site of the cancer, panendoscopy is repeated and blind biopsies taken from the nasopharynx, tonsils, base of the tongue or any other suspicious focus. If the primary lesion is still not identified, a needle biopsy of the neck lesion is in order. If an open biopsy is desired, the incision should be made keeping in mind the possibility of a later radical neck dissection.

Early injudicious incisional or excisional biopsy of a neck mass may result in contamination with and spread of cancer. Later surgery may be made unnecessarily difficult by a poorly-placed earlier incision or by obliterated tissue planes. Frequently, there is an unnecessary delay in the further evaluation and appropriate treatment of the primary lesion.

### Materials and Methods

From the surgical service of the Wheeling Division of the West Virginia University School of Medicine (Ohio Valley Medical Center), 48 cases of mass lesions of the neck are reviewed. These patients were admitted between 1971 and 1978. The term "mass" as used here excludes lesions of the thyroid, parathyroid and salivary glands. The patients were attended by different surgeons working independently. While the majority of the patients were treated by otolaryngologists, a small number were treated by thoracic, plastic and general surgeons. Some of the patients treated were referred from private practitioners or general surgeons after a variable amount of work-up. Thus, the amount of further work-up varied from part to the entire evaluation. In general, evaluation was orderly with concentration on the upper air and food passages. The average hospital stay was 15.4 days (range: 2-77 days).

*Sex and Age:* The average age of all patients was 60.5 (range: 17-87). Of the 48 patients in the study, 25 were men and 23, women. The majority of the patients were between 50 and 70 years of age (Table 1).

**TABLE 1**
**Age Distribution of Patients**

| *Age of Patients* | *Number of Patients* |
|---|---|
| Over 80 | 3 |
| 71-80 | 4 |
| 61-70 | 17 |
| 51-60 | 20 |
| 41-50 | 1 |
| 40 and below | 3 |
| Total | 48 |

**TABLE 2**

**Metastatic Carcinoma—Site of Origin**

| *Primary Site* | | *Number of Patients* |
|---|---|---|
| Head and Neck | | 28 |
| Tongue | 8 | |
| Larynx | 7 | |
| Hypopharynx | 4 | |
| Nasopharynx | 4 | |
| Tonsil | 2 | |
| Lip | 2 | |
| Nose | 1 | |
| Below Clavicle | | 8 |
| Lung | 5 | |
| Ovary | 1 | |
| Back | 1 | |
| Uterus | 1 | |
| Unknown Origin | | 1 |
| Total | | 37 |

*Anatomic Site and Classification:* 45 (93.8 per cent) of the 48 cases were malignant. Only three (6.3 per cent) were benign; 37 (77.8 per cent) of the 45 malignant lesions were of metastatic origin (Table 2), and eight (17.8 per cent) were due to lymphoproliferative disorders; 28 (63.2 per cent) were metastatic from origins above the clavicle while eight (17.8 per cent) were from origins below.

*Histology:* The histopathologic types represented in the 45 malignant cases included squamous cell carcinoma, lymphoma, lymphoepithelioma, transitional cell carcinoma, adenocarcinoma, and basal cell carcinoma.

*Squamous Cell Carcinoma:* There were 30 patients in this group representing 66.7 per cent of all metastases. Of these, there were eight from the tongue, seven from the larynx, four from the hypopharynx, two each from the tonsils, nasopharynx and lip, and one from an undertermined site.

*Lymphoma:* There were eight cases of lymphoma (21.8 per cent). Five of these were solitary nodes in the neck. Two of the remaining three were multiple bilateral cervical nodes. The remaining one case had multiple bilateral cervical, axillary and inguinal lymphadenopathy as well as an enlarged spleen.

*Others:* Two patients had metastatic basal cell carcinoma—one from the nose and the other from the back. There were two cases of nasopharyngeal lymphoepithelioma and one transitional cell carcinoma. There were single cases of adenocarcinoma of the uterus and ovary metastatic to the neck.

*Smoking:* Data on smoking were available on 28 patients. Nineteen of these were smokers. All except a pipe smoker, who had carcinoma of the lip, smoked from one to four packs of cigarettes a day. Of the 18 cigarette-smokers, 15 (83 per cent) had metastatic squamous cell carcinoma of the tongue, hypopharynx, larynx or lung. There were two cases in this group with lymphoproliferative disease and one with lymphoepithelioma of the nasopharynx.

There were nine known non-smokers: three of these had lymphoma, and there were single cases each of basal cell carcinoma of the nose, carotid body tumor, adenocarcinoma of the uterus and transitional cell carcinoma of the nasopharynx. Two patients had squamous cell carcinoma—one of the hypopharynx and the other of the base of the tongue.

**Treatment**

The patients are grouped according to the treatment they received except for the lymphomas and the benign lesions, each of which is grouped as such (Figure ).

*Radical Neck Dissection:* Thirteen patients were thus treated, with none done as a bilateral procedure. Three of these were done with total laryngectomy, with one death. The death occurred in a patient who developed severe abdominal pain, was explored 14 days after his neck operation, and succumbed 36 hours later. Excisional biopsy preceded neck dissection in only one instance in this group and it was the only tumor of unknown etiology in the entire series. Postoperative cobalt therapy was administered in five cases and declined in one.

*Cobalt:* Radiotherapy was the principal mode of therapy in 21 cases. These were all advanced or reccurent disease, and treatment for the most

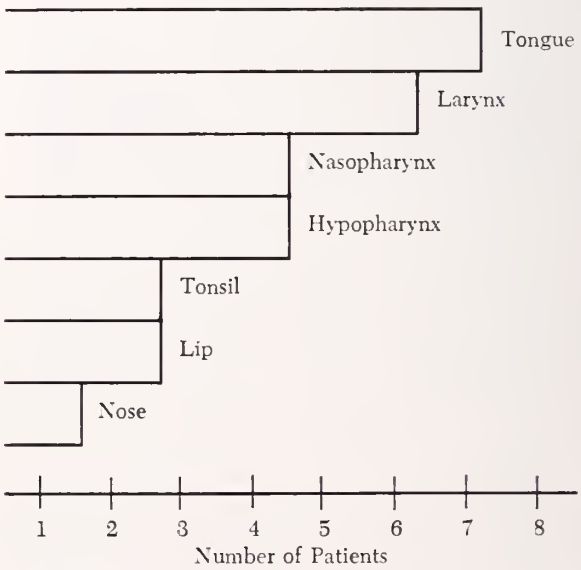


**Figure. Site of Origin of Cancer Above the Clavicle**

part was for palliation. Among those who were seen for the first time, biopsy for tissue diagnoses was taken in nine cases. Whenever feasible, therapy was administered on an outpatient basis and the patient followed by the attending physician in his office.

*The Lymphomas:* The eight patients in this group, seen with neck masses of four days' to one year's duration, were all treated by chemotherapy or cobalt. Two of these patients were sent back to their referring doctors for treatment while the rest were followed in the private offices or clinics of the attending physicians.

*The Benign Cases:* A 42-year-old man with a neck mass for nine months was found to have an abscess. It was drained and recovery was uneventful. A 23-year-old woman with several years of bilateral cervical, axillary and inguinal lymphadenopathy underwent cervical node biopsy and was found to have follicular hyperplasia and sinus histiocytosis. The third patient has a carotid body tumor which was excised, and he did well.

### Comments

The patient with a mass lesion of the neck must be approached in an organized manner.[4] In agreement with Barrie *et al*,[5] our study shows that the neck mass is most commonly representative of metastatic cancer. Further, the site of origin is most likely to be in the head and neck area. For this reason, early, meticulous examination of the head and neck is an absolute requirement. If the primary lesion is not found in the head and neck area, an orderly search below the clavicle is undertaken, starting with the chest, as justified by this study.

The majority of our patients were in their fifth and sixth decades and, in contrast with the study of Machetta *et al.*,[6] both sexes were about evenly represented. There were many smokers among patients with carcinoma, especially of the epidermoid variety. In this study, a significant group of patients (46.7 per cent) with metastatic neck masses had to turn to radiotherapy as a major mode of therapy. Radical neck dissection was the main course of treatment in 28.9 per cent of the cases.

### Summary

Mass lesions of the neck are most likely metastatic cancer, and biopsy must be the last, and not the first, resort. The records of 48 patients with mass lesions of the neck at the Wheeling Division of the West Virginia University School of Medicine (Ohio Valley Medical Center) from 1971-1978 have been analyzed. Of 45 patients who had metastatic cancer, the primary site was established in every case except one. The predominant primary site was in the head and neck. Below the clavicle, the commonest primary was in the lung. Radiotherapy was invaluable by itself or with surgery.

### References

1. Martin HE, Romieu C: The diagnostic significance of a "lump in the neck". *Postgrad Med* 11:491-500, 1952.

2. Bridger GP, Reay-Young P: Metastatic neck nodes of unknown origin. *Med J Australia* 2:49051, 1978.

3. Davis WH: Evaluation of the cervical mass. *J Fla Med Assoc* 65:758-759, 1978.

4. Doberneck RC: Diagnosis and treatment of the solitary mass in the neck. *Am Surg* March, 1974.

5. Barrie JR, Knapper WH, Strong EW: Cervical nodal metastases of unknown origin. *Am J Surg* 120: 466-470, 1970.

6. Marchetta FC, Murphy WT, Kovaric JJ: Carcinoma of the neck. *Am J Surg* 106:974-979, 1963.

# An Architect Designs A Needle

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*Young Christopher Wren, before attaining fame as an architect, and Robert Boyle, distinguished chemist, at Oxford University in 17th-Century England, conducted an experiment on a dog which led to the development of the hollow hypodermic needle. In the scale of human values, the experiment reaches the pinnacle.*

THE tall, gray spires of Oxford were silhouetted against a misty twilight sky; the shaven lawns had been deserted by pedagogue and scholar, and vesper had declared its daily truce with learning.

In the Warden's lodging in one of the University buildings two men stood with bated breath anxiously watching a dog that had been lashed to a table. The younger of the two men was Christopher Wren, not yet 35. In his fertile mind the germ plasm of an idea had developed. He had convinced his colleague, the distinguished chemist, Robert Boyle, that if he could put a pipe in the blood vessel of an animal that he would be able to inject drugs in large quantities directly into the blood stream. Boyle had respect for Wren's erudition and the two scientists were putting this idea into execution.

One of the superficial veins of the dog's hind leg was exposed. The fascia was dissected away and the ligatures tied around the vessel. A small brass plate was placed beneath the vessel to support it. By means of a lancet a small opening was cut into the vein large enough to insert a quill attached to a syringe. When the quill was securely ligated to the vessel an infusion of opium was injected.

What would happen? For the first time, on this planet at least, a medicine was dodging the stomach, intestines and liver and making its ingress directly into the blood stream.

### Opium Takes Effect

Anxiously, Wren and Boyle examined the dog; the breathing continued, the heart pounding tumultuously against its narrow chest wall in revolt against this invasion of foreign material. The injection was completed. The blood vessel was sutured; the animal struggled from the pain of the operation, while the two investigators watched breathlessly the outcome of the experiment. Slowly, with tottering legs, the animal rose from the table. It nodded. Morpheus must have its toll, and the animal slumped into a deep stupor.

Wren and Boyle knew that the opium was having its effect, but they were afraid that their test object would die. Furiously they whipped the dog up and down a neighboring garden to stimulate the animal out of the opium narcosis. They succeeded ultimately in saving the dog's life. The fame of the mysterious dog spread rapidly and this cost science the animal for further work. A group of curious people stole the dog.

Fired with enthusiasm by the success of this experiment, these brilliant investigators pushed forward their studies. They learned to insert the quill into the vein without the aid of the brass plate, using the index finger to support the vessel, just as is the custom in inserting glass tubes into blood vessels today.

Many other dogs were used: an infusion of oxide of antimony was injected. This is a powerful emetic drug, and the effect killed the dog. They observed how rapidly effective the drugs were when injected directly into the circulation.

### Blood Transfusion Discovered

Then they learned to attach the blood vessels of one dog to those of another through a quill—the art of blood transfusion had been discovered. Millions as yet unborn will be grateful for that day.

In May, 1665, the experiments were precipitously brought to an end. The London plague reached its peak that summer and there was a general exodus of people from the city, with its narrow streets and poor water supply. Wren was off to Paris, destined by fate to be saved from the plague.

Paris was to have its part in the molding of this master mind. The scientist, Wren, met the Earl of Albans, English Ambassador, in the French capital. Paris was building: the novel architecture captured Wren's imagination. The facade of the Sorbonne later made its impression on St. Paul's Cathedral, and Fontainebleau converted the scientist into an architect.

In August, 1666, London was razed to the ground by fire and Wren, scarcely waiting for the ashes to cool, began planning a new London.

As Surveyor-General, Wren's fame grew, and for 40 years after the great fire there was not an important building erected in or near London that Wren and his associates did not plan.

### Remain Friends

Boyle remained an experimenter and prolific writer. His law of gas volumes, which was probably suggested by Wren, was announced in 1669. Although the visit to France, the plague and the great fire were responsible for the divergence in the careers of these two scientists, their friendship continued, until the death of Boyle in 1691, through their activities in the Royal Society.

C. Whitaker Wilson claims that there were four great influences in the life of Wren: first, his father, who taught him loyalty to the throne of England; second, Holder, who taught him to love the heavens; third, Busby, who refined him by the discipline of the classics; and fourth, France, which challenged him to raise a dome mightier than those on her shores.

### Transcends Work as Architect

The fame of Christopher Wren, the architect, has echoed down through the centuries, but transcending this work is his experiment with Boyle. In the scale of human values it reaches the pinnacle. Out of his work developed the hollow hypodermic needle in 1852, contributing more to human comfort and happiness than the telephone or the electric light. Without it the powerful drug, adrenalin, would be lost to medicine. Banting and Best would have found insulin valueless and millions of diabetics would have died. Immunization against diptheria and its treatment would have been impossible.

As one stands at the grave of Wren in St. Paul's and reads the timeless epitaph, "If you seek a monument, look about you," one can envision without the magnificent cathedral of stone the work of the architect with Boyle immortalizing him in the temple of the living body through transfusions and intravenous medication . . . for an architect designed a needle.

## Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 ½ by 11 in.) white paper. Wide margins (at least 1 ¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

# Special Article

# Good Chances For Good Changes: Rehabilitation In West Virginia

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*New opportunities are emerging for better medical rehabilitation in West Virginia as a consequence of a West Virginia State Medical Association initiative to establish facilities, growing interest in the medical academic sector, and some new priorities by the West Virginia Vocational Rehabilitation Division. It is timely now to solve some old problems that have been obstacles to progress in the past. A broader understanding of who should do what for best results is needed for effective collaboration.*

THIS article describes some major new developments in rehabilitation in West Virginia; proposes a strategy to close out some old problems, and comments on some concepts and roles that need to be widely understood in order to facilitate achieving some of the improvements now coming within our grasp.

### New Developments

1. The West Virginia State Medical Association Rehabilitation Committee recognized a need for medical rehabilitation facilities in West Virginia. It arranged for a study of the demand and need for such facilities to be conducted by the West Virginia Department of Community Medicine. *Medical Rehabilitation Needs In West Virginia* by Pearson and Greenwood, on file at applicant hospitals and the WVU Department of Community Medicine, is a comprehensive report which estimates a need for 120 beds, together with outpatient services. This report additionally sets forth a wealth of information about the frequency distribution expected for various disability groups, the desirable characteristics for facilities and other matters.

Next, a public meeting was held convening representatives from the medical and academic communities, the Legislature, public agencies and others. This meeting produced a consensus of those present that these facilities should be established.

The Legislature appropriated $50,000 for use in the 1979-80 fiscal year for planning such facilities by interested hospitals. The following hospitals expressed interest in applying for a share of this planning money: Charleston Area Medical Center, Wheeling Hospital, Ohio Valley Medical Center, Inc. (Wheeling), St. Mary's Hospital (Huntington), Cabell-Huntington Hospital, West Virginia University Hospital, Oak Hill Hospital and St. Joseph's Hospital (Parkersburg).

This initiative by the Association is potentially a major public service to West Virginia. Its success is by no means assured at this point since these facilities are very expensive and money is tight. Physicians and others need to know of this since it will require broad, vigorous, and sustained support if it is to be brought to fruition.

2. Marshall University Medical School and West Virginia University Medical School are both showing signs of growing interest in medical rehabilitation teaching and service programs. Dr. Robert Coon, Dean at Marshall; and Dr. R. John C. Pearson, Chairman, Community Medicine, WVU, continue to be instrumental in the initiative to develop medical rehabilitation facilities in the State. Both schools have supported the candidacy of their hospitals for planning funds. Both will offer student electives in rehabilitation medicine at the West Virginia Rehabilitation Center and both will use Center staff additionally for presentations to medical school classes.

3. The West Virginia Division of Vocational Rehabilitation has a new Director, Mr. Earl W. Wolfe. He is very interested in developing more effective physician-Agency collaboration. A change in leadership presents the opportunity to "close the book" on old controversies without defensiveness and go after new, productive approaches.

4. The Rehabilitation Agency is vigorously shifting its emphasis to comprehensive quality services for the severely disabled and away from volume services to the minimally disabled. This

changes the types of referrals it seeks from physicians (a matter worthy of note) and fosters the growth of Agency capability to be of substantial help to the physician in those difficult cases where the constellation of problems ushered in by the severe impairment threatens to overwhelm patient and family.

5. The Agency's main facility, the West Virginia Rehabilitation Center, has launched a quality and capacity-building program. We intend to eliminate waiting lists, augment our specialty expertise in physical and rehabilitation medicine, and improve coordination and continuity of care intra- and extra-institutionally among the many disciplines usually required to contribute to each patient's care. This means the attending physician back home as well as our own staff.

### Old Problems

For some years, the State Medical Association's Rehabilitation Committee has taken the Agency to task because of low physicians' fee schedules; counselor actions that are disruptive of doctor-patient relationships; poor Agency reporting back about clients to referring and attending physicians; involvement of the Agency in cases where they are not needed, thereby complicating things for the physician; and long waiting for patients to be admitted to the West Virginia Rehabilitation Center.

The Agency has had its problem list too, of course: non-referral by physicians to us of patients who badly need help with the vocational consequences of their disability; insufficient physician participation in evaluating and treating our clients; minimal functional and prognostic comments in many physician reports to the Agency (the key considerations in a vocational program), and use of our program as a fiscal resource for the physician/hospital for indigent patients with medical needs as contrasted to involving us with patients on the basis of their disability-induced vocational problems.

To a considerable degree, these two lists of problems feed each other. The high-volume style of Agency operation fostered use of the Agency as a fiscal agent for medical purposes, and discouraged physicians expecting much Agency help on the cases with tough vocational problems. Low fees fostered non-participation and insufficient reports. Lack of appropriate referrals, together with a high-volume type program, prompted counselors to get involved with clients when the vocational problems were minimal, etc.

To break these vicious circles, the Agency has earnestly addressed each of the problems concerning which the Association's Rehabilitation Committee has faulted us. We raised our physician fees again by 20 per cent on November 1. Granted, this leaves us well short of average charges, but it nonetheless is a major accommodation by the Agency which is experiencing virtually stationary appropriation levels, and can only finance this increase by cutting other program expenditures.

### Procedural Safeguards

The Agency has developed specific counselor procedural safeguards to preserve doctor-patient relationships, cleared these with your Rehabilitation Committee, and implemented them. We are now instituting report-back procedures to attending and referring physicians from both our field offices and the Center. We have cut our rehabilitation numbers in half as we disengage from a volume orientation and shift to the much more expensive and time-consuming comprehensive service to the severely disabled.

In recent months, there has been no waiting list for admission to the Medical Services Section of the Center. Probably we shall see a waiting list again, but with our expansion of capacity and emphasis on proper utilization, the problem may disappear permanently in the near future.

With regard to agency interference in doctor-patient relationships, both the Association's Rehabilitation Committee and the Agency are unaware of continuing problems. We believe the problem is essentially solved. It may be, however, that we are not hearing from physicians who are continuing to have problems. Physicians are urged to keep either the Committee members or the writer advised about this. Association members will receive a questionnaire shortly from the Association's office designed to assure that the Committee has accurate information on the status of these old problems and many others. Since a number of changes have occurred and others are being inaugurated, it is important that responses describe current experience rather than events of a year or more ago.

### Concepts and Roles

The main mission of the West Virginia Division of Vocational Rehabilitation is to bring about employment (including homemaking) of disabled persons. Thus, it serves those who have both a substantial handicap to employment arising out of their disability, and a likelihood of benefiting in terms of employability

from the services given. Medical services is one of many types of services which may help the disabled person to work.

This mission statement clarifies whom we should be serving—those with a work handicap and with a reasonable work prognosis. It follows that many *medical* rehabilitation needs are not covered — persons who are not in vocational trouble despite their impairment, and persons who can't be vocationally salvaged through medical and other services.

Thus we see a need for medical rehabilitation facilities in the State because vocational rehabilitation does not address the total need.

This mission statement also clarifies the need for reports from physicians about the impairment (so that the vocational implications may be perceived), and the need for preauthorization for services (so that the vocational relevance of the service can be established before the commitment to pay is made).

Frustration accompanies efforts by patients/physicians/counselors to use the vocational rehabilitation program as an ace-in-the-hole third-party medical fiscal agent. The eligibility requirements, the process to establish it, the handling of evaluation and therapy as separate issues, the preauthorization, etc., make no sense in a medical care program. When the real objective is medical attention to a health problem, the VR process, which is designed for a different purpose, seems to overload every step with mindless bureaucracy. Additionally, VR is much too expensive and slow to be a suitable resource for just buying glasses or removing a gall bladder, for example.

It is most important that the Agency not only divest itself of the third-party medical fiscal agent role, but that it also invest itself early in all the severely disabled with vocational aspects to their problems and some hope of work potential.

### Non-Medical Consequences

Severe disability almost always brings serious non-medical consequences in its wake. The vocational, economic, psychological and social consequences become greatly handicapping. The usual physician has neither the time nor generally the expertise/connections/resources to deal with these.

Disability generally brings patients to doctors early, but to DVR late. The time lapse erodes the patient's self-confidence, his connections with employers, work skills, his family's expectations of his being the breadwinner, etc. Accommodation to disability insurance as a way of life then makes the Agency's vocational rehabilitation job something between difficult and impossible. Thus we need heightened physician awareness of all this so that referrals of these cases will be earlier and more commonplace.

Finally, the congruity between the vocational rehabilitation philosophy and the prevailing viewpoint among physicians that all persons have a responsibility to do what they can to avoid dependency does need highlighting. VR is in the enviable position of being a very humanitarian program operating at a remarkable profit. A well-run VR program will, over the lifetime of its clients, save $5.00 for every dollar spent.

This point is noteworthy at this time when many physicians and others have grave concerns about high taxes and government fiscal solvency. Surely a program which can, if well run, realize a five-to-one return on the investment should be doing all the business that is relevant to it. To be well run, it must have competent physicians' participation and referrals, among other things.

### Summary

In summary, some new opportunities have arisen — some momentum toward establishing medical rehabilitation facilities; growing interest in medical rehabilitation teaching and service in State medical schools, and a period of rapid change and renewal in the State vocational rehabilitation agency.

Some old problems in the relationships between the State Medical Association and the Agency have cast them into adversary postures to a destructive extent. Recent joint efforts by the Association and the Agency seem to be bringing these under control, but feedback is needed to validate this conclusion.

An understanding of the role of the State VR Agency as a vocational program can strengthen Agency-physician effectiveness in collaborative services in more adequately meeting the problems of the severely disabled.

113th ANNUAL MEETING

of the

# *West Virginia State Medical Association*

*The Greenbrier*

AUGUST 20-23, 1980

# PLAN NOW TO ATTEND

# *The President's Page*

*Guest Author*
*Betty (Mrs. D. Sheffer) Clark, President*
*Auxiliary to the*
*West Virginia State Medical Association*

## A LOUDER VOICE

With 1980 being an election year, perhaps we can reflect on what's in store for the health care industry. We can make some predictions. Having seen health care issues tossed like a ball from player to player in the political game already, we know we are going to see more of the same. The scholarly view of Milton Eisenhower, who served under eight presidents, rings all too true. To quote him in a recent interview (*Time* Magazine, October 29, 1979), "Those in Congress vote for re-election, not [for] what helps the nation."

However, we are assured there is reason for some optimism. Harry Schwartz, in his last editorial before retiring from the *New York Times* (September, 1979), asked, "Whatever happened to the National Health Care Crisis?" then observed, " . . . Fortunately, it is now the government itself that is puncturing yesterday's most alarming accusations. It is thus creating a more rational atmosphere in which to discuss the real, current problems of this country's huge and complex medical system."

Assuming Mr. Schwartz to be correct, how did we come from the "alarming accusations of yesterday" to this "more rational atmosphere?" Who has been working for the medical profession to bring about the change? The obvious answer is the American Medical Association. Who has helped to bolster the cause while working in community service, and deserves more credit than sometimes given? The obvious answer is the AMA Auxiliary.

These answers may be obvious to you and me because we belong to our respective societies and auxiliaries, and we are informed about the actions and work of the AMA. However, there are many physicians and physicians' spouses we know in West Virginia who have not gotten the message. They do not see that through membership we have a voice in the future, and that more members means having a louder voice. A louder voice puts more emphasis where it belongs as we respond to legislative alerts when elected officials need to be made aware of medicine's views on crucial legislation. Let's resolve to get this message heard. It is a job that needs doing!

Long ago, Plato said that " . . . it is the punishment of wise men who do not participate in the affairs of government to live under the government of unwise men."

Betty Clark

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

April is upon us and all the pessimists among us can once again wonder at the unexpected circumstances allowing them to view another Spring.

**TAX WORRIES**

The certainty that this will be their last Spring yearly adds to the exquisite beauty and poignance of the experience.

The ability to so magnify the sensuous joys of the season surely marks these sad prophets the most fortunate of men.

Not so for those of us who, more discriminating in our foreboding, confine our worries to the inevitability of the latter of that doleful pair, death and taxes.

April is really no more than an exclamation point at the end of a synopsis describing one year's misery. Were the complete and unabridged story to be told, shelf space suitable for a set of encyclopedias would be required.

Most Americans know that government is wasteful and inefficient. To many, the IRS is just one giant toilet bowl—a place where something, once of value, is deposited and then is seen no more. All this without the accompanying relief afforded by the act thus symbolized.

Headaches begin to pound and backs to ache when one dwells for very long on the multitude of gross and petty, simple and sophisticated methods government has devised to extract taxes. Most find it is best to avoid the aches and just to think as little as possible on the subject.

One curious development seems to be the assumption of a certain degree of status related to the tax bracket to which the taxpayer has risen. What a strange conceit! England is the place often smugly pointed to as the epitome of an anachronistic example of class distinctions and class consciousness. Are we witnessing the anlage of a new royalty? Taxpayer, Fiftieth Percentile, a title bestowed by the Commissioner of Internal Revenue, might be the newest peerage.

No, it will never work. Prospects of an early elevation to the purple are just not that appealing. Something is bound to be wrong. We would probably have to live in a drafty old castle. The servants would probably be unionized, too, or else lazy. They might buy a few off with deals like that, but not us.

We're going to go right on talking and worrying.

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**CHANGE IN ATTITUDE**

As a general rule, each session of a state legislature is markedly different. While some issues, such as capital punishment, coal mine safety, branch banking and perhaps abortion, can become on-going standbys in West Virginia, the particular tenor of the times—and the economy—play major roles in what is and is not considered in a given year.

The 1980 session had its own identifying features, and from the standpoint of Medicine, there were some encouraging elements. There was a heartening attitude of interest and cooperation, in committees and on the floor, with regard to matters doctors brought to legislators' attention. A wrap-up story in *The Journal's* General News Section reflects this fact.

Without embarking on an ego trip, the State Medical Association and its members can claim substantial credit for this atmosphere. The Association went to the Legislature with a program, reflecting honest assessments of problems and concerns and offered in a positive manner.

There were, of course, some bills the Association's members again—or for the first time—didn't like, and the Association expressed its views on those as it has in the past. But 1980 was not a year in which anyone could say, as has been the case on past occasions, "Here comes the State Medical Association again, opposed to everything."

The Association's Executive Committee, Council, Committee on Legislation, House of Dele-

gates and other components generally had the enthusiastic support of physicians in a clear attempt to turn its legislative posture around. In that endeavor, it enjoyed significant success.

There remains much work to be done on some of this year's efforts. Further attention certainly will have to be directed to the State Medical Practice Act. That work will be continued during the months leading to another legislative session next January. Other goals need to be developed and pursued.

But from the standpoint of posture, the state's physicians have generated some positive new momentum and respect. Legislators have recognized, and welcomed, this fact, and haven't hesitated in numerous instances to say so.

If the Association is to promote the public health, in a responsible manner clearly dictated by its Constitution, more of the same must be accomplished. This year indicates that can, and will, be done.

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**FTC SETBACKS**

The U. S. Senate has adopted legislation constraining the Federal Trade Commission's authority — and failed by only two votes to approve an amendment specifically blocking the agency from further activities against the medical, legal, dental, veterinary and other health professions as well as their respective nonprofit associations.

On the same recent day, the U. S. Court of Appeals in Washington, D. C., sent back to the agency its proposal to prohibit all state restrictions on the advertising of eyeglasses and services, suggesting that the FTC may have gone too far in pre-empting states' powers.

Apparently mindful of the hostility building up in Congress, the FTC—on the eve of the Senate vote—refused to take any immediate action on staff proposals to limit physicians' membership on the boards of Blue Shield plans. The matter was made a proposal for public comment on what course the agency should take, including the option of no action at all.

The amendment defeated 45-47 on the Senate floor would have prohibited the FTC for two years from overriding state laws and pre-empting state regulations covering the legal and health professions. Senator Jennings Randolph of West Virginia voted for the amendment in support of Medicine's position on the issue. It would not have affected current FTC cases, including the decision to act against the American Medical Association's ethical strictures against improper advertising.

Senator Wendell Ford, Kentucky Democrat and floor manager of the Senate bill, argued against the amendment on grounds that it might jeopardize the entire measure. But he said he was sympathetic, and "vigorous" hearings on the issue would be scheduled soon. Ford also said he had talked with the FTC and it had "agreed to hold off."

Senator James McClure, Idaho Republican and sponsor of the amendment, told the Senate that since 1976 the FTC has sought "questionable statutory jurisdiction over nonprofit professional associations by pursuing complaints against the American Dental Association, the AMA and various state and local nonprofit professional associations regarding ethical restrictions on advertising of professional services." He said the FTC proceedings have continued despite the fact that the associations have conformed their ethical codes with the Supreme Court decisions in the field.

The Senator noted that 17 state attorneys general had joined the optometric and medical professions in protesting the "eyeglass" FTC ruling.

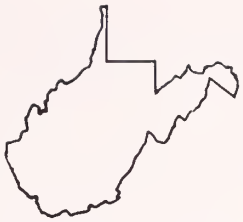
"We believe it is time for Congress . . . to call a temporary halt to this uncontrolled misallocation of public funds, and to begin to rectify these unnecessary and unauthorized acts of the FTC by which it is attempting to substitute its 'legislation' judgment for that of the respective states and Congress," Senator McClure said.

Under a Senate admendment, approved 87-10, the House and Senate Commerce Committees would have 20 days to review an FTC rule before it could take effect. If either committee objected, both House and Senate would have to agree within 60 days with the President concurring for the rule to be invalidated.

The House FTC bill would allow either House or Senate to reject an FTC trade rule within 60 days, the so-called one house vote.

AMA Executive Vice President James H. Sammons, M. D., has sent a letter to the senators who supported the McClure amendment, commending them for their stand.

# GENERAL NEWS



## AMA President To Speak At Annual Meeting

Dr. Robert B. Hunter, who will be installed as the President of the American Medical Association in July, is scheduled to speak during the State Medical Association's 113th Annual Meeting August 20-23 at the Greenbrier in White Sulphur Springs.

The Program Committee announced that Doctor Hunter, of Sedro Woolley, Washington, is to address the first session of the House of Delegates at 3 p. m. on Wednesday, August 20.

A family physician, the AMA President Elect has been a member of the AMA Board of Trustees since 1971, and was Chairman of the Board in 1977-78 and 1978-79.

He was a member of the AMA House of Delegates from 1964 to 1971, and is a former member of the AMA's Council on Constitution and Bylaws and the PSRO Advisory Committee.

A charter member of the American Board of Family Practice, Doctor Hunter is in a three-way partnership in General Practice and General Surgery in Sedro Woolley. He also is a member of the active staff of United General Hospital there, and is a faculty member at the University of Washington School of Medicine, Department of General Practice.

#### Former State President

Doctor Hunter was President of the Washington State Medical Association in 1963-64, and served as Chairman of the Washington State Medical Disciplinary Board from 1964 to 1970.

He was graduated from the University of Washington and received his M. D. degree in 1943 from the University of Pennsylvania Medical School.

Convention activities will get under way with a 2 P. M. meeting of the Association's Executive Committee on Tuesday, August 19; the usual preconvention meeting of the Council at 9:30 A. M. on Wednesday, and the opening House session that afternoon.

Delivering the keynote Thomas L. Harris Address during 9 A. M. opening exercises on Thursday, as announced previously, will be Dr. William R. Barclay, Editor of The Journal of the American Medical Association (JAMA). The first general session will be held immediately following the opening exercises, with general sessions also scheduled for Friday and Saturday mornings.

#### Dermatologists to Speak

Two of the speakers for the first general session, also as announced previously, will be dermatologists from the University of Maryland School of Medicine. They are Drs. Harry M. Robinson, Jr., Professor and former head of the Division of Dermatology, and Joseph W. Burnett, Professor and currently Head of Dermatology.

Doctor Robinson will speak on "Advances in Photochemotherapy," while Doctor Burnett's topic will be "Diagnostic Dermatologic Methods."

In addition to the above talks, there will be a paper on foods and medications during the first

**Robert B. Hunter, M. D.**

general session and, during the Friday morning session, presentations on psychiatry and children's learning disorders.

The Saturday morning session will feature talks on AMA services and the activities of the AMA's Washington office.

The general convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 22).

## Association Program Wins Legislative Approval

The State Medical Association won enactment of its legislative package during the session ended in early March.

The Legislature passed and sent to the Governor legislation to:

—Rewrite the State's Medical Practice Act.

—Provide immunity for records, discussions, etc., of peer review, tissue, medical audit and other committees, particularly at the hospital level.

—Write into the statute a Uniform Brain Death Act.

More detail will be provided on these various pieces of legislation later, because the legislative action came as the deadline of this issue of *The Journal* approached.

Also passed was a bill changing from a physician to a consumer majority the control of medical service (Blue Shield) corporation boards. The Medical Association Council voted not to oppose that legislation.

Again failing to win final passage was a bill, much more tightly written than in previous years, to permit the manufacture and limited use of laetrile in West Virginia.

Also again rejected by a House committee was a Senate-passed bill to provide certain exemptions from compulsory school immunization programs because of religious beliefs.

Another bill which failed to win final approval in the closing hours was a proposed voluminous rewrite of the State's Certificate of Need law to incorporate provisions of new Federal legislation enacted last summer.

**To Succeed Doctor Ward**

Plans also call for the usual President's Reception on Wednesday evening, August 20, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P. M. on Saturday. At that House session, Dr. L. Walter Fix of Martinsburg will be inaugurated as President to succeed Dr. Stephen D. Ward of Wheeling.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. D. Sheffer Clark of Huntington in charge as the Auxiliary's President, again will run concurrently with the Association's convention.

More specific information relative to other general session topics and speakers will be provided in upcoming issues of *The Journal.*

Members of the Program Committee are Dr. M. D. Reiter of Wheeling, Chairman; Doctor Fix, and Drs. David K. Heydinger of Marshall University's School of Medicine in Huntington; Joseph B. Reed, Buckhannon; Stanley Roy Shane of the West Virginia School of Medicine faculty in Morgantown, and John F. I. Zeedick of South Charleston.

# *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*Current Medical Diagnosis & Treatment*, by Marcus A. Krupp, M. D., and Milton J. Chatton, M. D. 1116 pages. Price $19. Lange Medical Publications, Los Altos, California 94022. 1980.

*Handbook of Pediatrics, 13th Edition*, by Henry K. Silver, M. D.; C. Henry Kempe, M. D.; and Henry B. Bruyn, M. D. 735 pages. Price $9.50. Lange Medical Publications, Los Altos, California 94022. 1980.

*Handbook of Poisoning: Prevention, Diagnosis and Treatment, 10th Edition*, by Robert H. Dreisbach, M. D., Ph.D. 578 pages. Price $9. Lange Medical Publications, Los Altos, California 94022. 1980.

## Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal.)

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Charleston and Wheeling campuses as well as in Morgantown. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S.E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

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| April 18 | Morgantown | 6th Annual ENT Teaching Day |
| April 19 | Wheeling | Annual Postgraduate Day in Surgery |
| April 26 | Morgantown | W. Va. Assn. of Pathologists, Scientific Session |
| May 8-9 | Morgantown | Health Officers Seminar |
| June 7 | Morgantown | Anesthesia Update '80 |
| June 7 | Charleston | 7th Annual Surgery Conference |

**Visiting Professors**

(Morgantown)

April 3-4 *Dept. of Obstetrics and Gynecology*: "Perinatal Outcome in Pregnant Epileptics" and "Hyperthyroidism in Pregnancy," Luis B. Curet, M. D., University of Wisconsin, Madison.

April 18 *Dept. of Radiology*: Melvin Clouse, M. D., Chairman, Department of Radiology, New England Deaconess Hospital, Boston.

May 16 *Dept. of Radiology*: David H. Baker, M. D., Professor and Director, Pediatric Radiology, The Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City.

May 29-30 *Dept. of Obstetrics and Gynecology*: "The Obstetrician's Unique Challenge—Conflicting Risks of Two Patients" and "Premature Rupture of the Membranes," Watson A. Bowes, M. D., University of Colorado, Denver.

*Dept. of Anesthesia*: One Thursday each month, 4 p.m.

*Dept. of Medicine*: Variable—incorporated in Grand Rounds

*Dept. of Family Practice*: Variable—incorporated in Grand Rounds

## Wildwater Surgical Conference In Charleston June 7

The Seventh Wildwater Surgery Conference will be held on Saturday, June 7, at the West Virginia University Medical Education Building in Charleston.

Sponsors are the Charleston Division/WVU Medical Center and the Charleston Area Medical Center.

Registration will begin at 8 A.M., with the scientific program to begin at 9:15 A. M.

The speakers and their topics will include "Coronary Bypass Surgery, Update 1980," Jay L. Ankeney, M. D.; "Breast Cancer — Clinical Trials," Paul G. Koontz, Jr., M. D.; "Surgical Considerations in Biliary Tract Obstructions," Richard T. Myers, M. D.; "Bypass Surgery for Morbid Obesity," Mark Ravitch, M. D.;

"The Pathologist Looks at Malignant Disease of the Thyroid," Frank Mantz, M. D.; "Staging Laparotomy for Hodgkin's Disease," J. Michael Sterchi, M. D.; "Evaluation of the Thyroid Nodule," Caldwell B. Esselstyn, M. D., and "Impotence—Part II," Drogo K. Montague, M. D.

For additional information, call the WVU Charleston Office of Continuing Education at (304) 347-1242.

Conference registrants also are invited to participate in a Wildwater Expedition on New River from Thurmond to Fayette Station on Friday, June 6. The fee for this expedition is $47. Reservations, which will be limited, can be made by calling (304) 348-5511.

## Endocrine And Breast Surgery Program In Wheeling

Guest speakers from Ohio and Pennsylvania will participate in a one-day program on "Endocrine and Breast Surgery" at the Ohio Valley Medical Center in Wheeling on April 19.

Sponsors are the hospital's Department of Surgery and the Wheeling Area Continuing Medical Education Program.

The program will begin at 8:05 A. M. with the following speakers and topics:

"Parathyroid Update 1980" — Caldwell B. Esselstyn, M. D., Department of Surgery, Cleveland Clinic; "Pancreatic Endocrine Tumors"—Larry C. Carey, M. D., Professor and Chairman, Department of Surgery, Ohio State University;

"The Management of Surgical Lesions of the Adrenal Gland" — Ralph A. Straffon, M. D., Head, Department of Urology, Cleveland Clinic, and "Surgical Implications of Thyroid Disease" —Charles G. Watson, M. D., Associate Professor of Surgery, University of Pittsburgh.

The morning session will conclude following a panel discussion moderated by Doctor Watson.

Papers for the afternoon session will include "Post-Cholecystectomy Syndromes" — Doctor Carey; "Risk Factors Associated with Benign and Malignant Breast Disease" — John P. Minton, M. D., Professor of Surgery, Ohio State University;

**A session on "Current Controversies in Medicine" was held during the 13th Mid-Winter Clinical Conference sponsored by the State Medical Association and the West Virginia and Marshall University Schools of Medicine in Charleston in January. Seated, from left, are Drs. Bruce S. Chertow, Huntington, and Margaret J. Albrink, Morgantown, speakers; standing, from left, Drs. John E. Jones, Morgantown, who presided, and Kenneth S. Scher, Huntington, a speaker.**

"Surgical Options in Breast Cancer"—Doctor Esselstyn, and "Surgical Management of Breast Cancer after Radiation and Chemotherapy Have Failed"—Doctor Minton.

The program will conclude following a 4 P. M. panel discussion moderated by Edward C. Voss, M. D., Wheeling surgeon and Clinical Associate Professor of Surgery, West Virginia University School of Medicine.

The program meets the criteria for eight hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

## State Pediatricians Plan April 10-11 Meeting

The program has been completed for the spring meeting of the West Virginia Chapter, American Academy of Pediatrics, April 10-11 in Charleston at the Holiday Inn Charleston House.

The meeting will begin at 1 P. M. on Thursday, April 10, with opening remarks by Herbert H. Pomerance, M. D., of Charleston, Chairman of the West Virginia Chapter.

The speakers and their topics will include "What's New in Neonatology"—Ian Holzman, M. D., Assistant Professor of Pediatrics and Obsterics and Gynecology, University of Pittsburgh School of Medicine; "Emerging Patterns of Child Abuse in West Virginia" — Barbara L. Tenney, M. D., Associate Professor of Pediatrics, West Virginia University School of Medicine;

"Short Stature: Management in Pediatrics" —Alan D. Rogol, Ph. D., M. D., Associate Professor of Pediatrics and Assistant Professor of Pharmacology, University of Virginia School of Medicine, and "Evaluation of the Young Febrile Child"—Edwin L. Anderson, M. D., Assistant Professor of Pediatrics, WVU Charleston Division.

Drs. Thomas G. Potterfield of Charleston, Program Chairman, and Gilbert A. Ratcliff, Jr., of Huntington will serve as moderators for Thursday afternoon sessions.

"A Cultural M-A-P: Medicine-Art-Pediatrics" will be the topic of the address by the Friday evening banquet speaker, Nancy Beers, Curator of Fine Arts Museums at Sunrise, Charleston.

A business session beginning at 8:30 will be conducted Friday morning by Doctor Pomer-

ance, followed by a scientific session at 10:15 A. M. Speaking during this session, moderated by Dr. George A. Shawkey of Charleston, will be Doctor Rogol, on "Thyroid Problems in Pediatric Practice," and Doctor Anderson, "Ampicillin-Resistant H. Influenza Infection in West Virginia."

Dr. Edwin P. Stabins of Charleston will moderate the Friday afternoon session. The speakers and their topics will be "Treatment of Child Abuse and Neglect" — Doctor Tenney; "The Practicing Pediatrician as Neonatologist" — Doctor Holzman, and "Current Controversies in Infant Feeding"—Henry P. Staub, M. D., Professor of Pediatrics, Marshall University School of Medicine.

## Senate Confirms Nominations Of Doctors To Boards

The State Senate has confirmed nominations of several physicians submitted by Governor John D. Rockefeller IV for various state boards and commissions. The list includes:

Drs. Charles A. Hoffman of Huntington, J. Amil Ahmed of Beckley and Anthony A. Yurko, Weirton, Medical Licensing Board; Ward Maxson and William C. Revercomb, both of Charleston, Driver's Licensing Advisory Board; Dominic A. Brancazio, Weirton, Board of Health; William C Morgan, Jr., Charleston, Board of Hearing Aid Dealers; D. Sheffer Clark, Huntington, Commission on Post-Mortem Examinations.

**Dr. Alvin L. Watne, left, Morgantown, chats with Drs. Kenneth G. MacDonald, Sr., center, Charleston, Treasurer of the State Medical Association, and Joseph T. Skaggs, Charleston, Co-Chairman of the Program Committee for the 13th Mid-Winter Clinical Conference. Doctor Watne was a speaker for the session on "Current Controversies in Medicine" during the January conference in Charleston.**

## State Anesthesiologists To Meet In June

Four guest speakers will participate in the annual meeting of the West Virginia State Society of Anesthesiologists June 6-7 at Lakeview Inn and Country Club in Morgantown.

The meeting will begin with a dinner session Friday evening, June 6, with the scientific program to be held Saturday.

Guest speakers and their topics will include "Arrhythmias During Anesthesia" — Nabil Fahmy, M. D., Harvard Medical School; "The Current Status of Epidural and Spinal Anesthesia"—William F. Kennedy, Jr., M. D., University of Washington;

"Anesthetic Management of the Geriatric Patient"—Monte Lichtiger, M. D., Mount Sinai School of Medicine, New York City, and "Basic and Clinical Pharmacology of Present and Future Neuromuscular Blocking Drugs" — John J. Savaresc, M. D., Harvard Medical School.

Speakers from the Department of Anesthesiology, West Virginia University Medical Center, will be Yadin David, M. Sc., whose topic will be "Transcutaneous-Arterial $PO_2$ as a Perfusion Index in Post-Cardiac Surgery in Children;" David J. Smith, Ph. D., "Endogenous Opiates," and Frank Zavisca, M. D., "Anesthetic Implications of Antihypertensive Drugs."

For additional information, contact Richard B. Knapp, M. D., Professor and Chairman, Department of Anesthesiology, WVU Medical Center, Morgantown 26506; or call (304) 293-5411.

## Dr. T. Keith Edwards Wins Magazine Prize

Dr. T. Keith Edwards of Bluefield is the grand prize winner of the 1979 *Medical Economics* awards for best original articles by physicians.

The article, "I Was Sold On Recertification—Until I Tried It," was published in the July 23, 1979, issue of *Medical Economics*. It dealt with the difficulty encountered when a physician undergoes the recertification process.

The grand prize was a week for two in Hawaii. Doctor Edwards is to make the trip this month.

The winning entry was one of some 350 submitted to the magazine during the year. Doctor Edwards is an obstetrician-gynecologist.

## New Drug Evaluations Volume Available

The physician confronted with a choice among a number of drugs for a particular disease wants to know what drug to select from among those available, what the benefit-risk ratio is, and what is the effective dose.

The newly-published fourth edition of *AMA Drug Evaluations* provides answers to these and many more questions scientifically and objectively. Information on indications, preferred and alternative drugs, adverse reactions and precautions, drug interactions and preparations is readily available to the practicing physician. When possible, preferred drugs are distinguished from acceptable drugs, and those whose use cannot be advised or recommended are denoted.

*AMA Drug Evaluations* is the result of a joint scientific effort by the staff of the AMA Department of Drugs and the American Society for Clinical Pharmacology and Therapeutics, as well as by more than 300 physicians and other health professionals who served as consultants and reviewers during the book's preparation.

Evaluation of more than 1,300 drugs, including 57 new entities: new chapters on Antiviral Agents, Parenteral and Enteral Nutrition, Immunomodulators, and Agents Used to Treat Infertility; and increased emphasis on investigational agents and new indications and doses for older drugs highlight this new edition.

Other useful features in this expanded 1,522-page volume include chapter outlines, structural formulae, extensive use of tables, listing of dosage forms and sizes by both generic and trademark names, ingredient information on mixtures, selected references for further reading, and a comprehensive index.

The book may be ordered for $48 from Order Department, OP-075, American Medical Association, P. O. Box 821, Monroe, WI 53566.

## On National Committee

Dr. Del Roy R. Davis of Kingwood has been named to the Publication Committee of the American Academy of Family Physicians (AAFP).

The Publication Committee is in charge of all official publications of the Academy, the principal ones being *American Family Physician* and the *AAFP Reporter*.

Doctor Davis will be a 1981 AAFP Delegate from the West Virginia Chapter.

# *Medical Meetings*

April 2-8—Am. College of Allergists, Washington, D. C.

April 10-11—W. Va. Chapter, Am. Academy of Pediatrics, Charleston.

April 11-12—W. Va. Assn. of Blood Banks, Parkersburg.

April 11-12–33rd. Annual Stoneburner Lecture Series, Med. College of Va., Richmond.

April 11-12—Pediatric Pulmonary Seminar (Am. Lung Assn. of W. Va., etc.), Pittsburgh.

April 12—Child Abuse Conference (W. Va. Branch, Am. Med. Women's Assn.), Huntington.

April 17-18—Rural Health Conference, Boston.

April 17-20—Mo. State Med. Assn., Jefferson City.

April 18—Mood Disorders in Children (Children's Hospital National Medical Center and George Washington University Med. Center), Washington, D. C.

April 18-20—Scientific Assembly, W. Va. Chapter, AAFP, Morgantown.

April 19-24—Am. Academy of Pediatrics, Las Vegas.

April 20-23—W. Va. Academy of Ophthalmol. & Otolaryngol., White Sulphur Springs.

April 21-25—Am. Roentgen Ray Society, Las Vegas.

April 24-26—76th Congress on Med. Education, Chicago.

April 28-30—Southeastern Surgical Congress, Atlanta.

April 28-30—Am. Assn. for Thoracic Surgery, San Francisco.

April 28-May 2—Am. Pediatric Society, San Antonio.

April 30-May 2—Med. & Chirurgical Faculty of the State of Md., Hunt Valley, Md.

May 1-3—W. Va. Chapter, ACS, White Sulphur Springs.

May 5-8—Am. College of Obstetricians & Gynecologists, New Orleans.

May 7-10—Va. Society of Ophthalmol. & Otolaryngol., Inc., Williamsburg.

May 9-11—Am. College of Nuclear Med., Montreal.

May 10-15—Ohio State Med. Assn., Cincinnati.

May 15-18—ASIM, Washington, D. C.

May 17-23—Am. Gastroenterological Society, Salt Lake City.

May 18-21—Am. Thoracic Society, Washington, D. C.

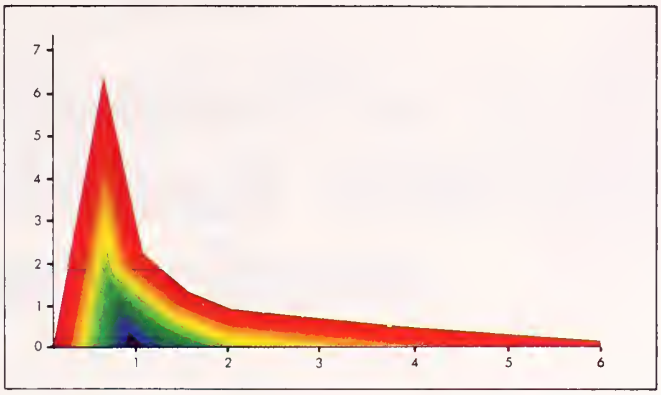
May 18-22—Am. Urological Assn., San Francisco.

July 20-24—AMA House, Chicago.

**Aug. 20-23—113th Annual Meeting, W. Va. State Assn., White Sulphur Springs.**

Oct. 6-9—AAFP, New Orleans.

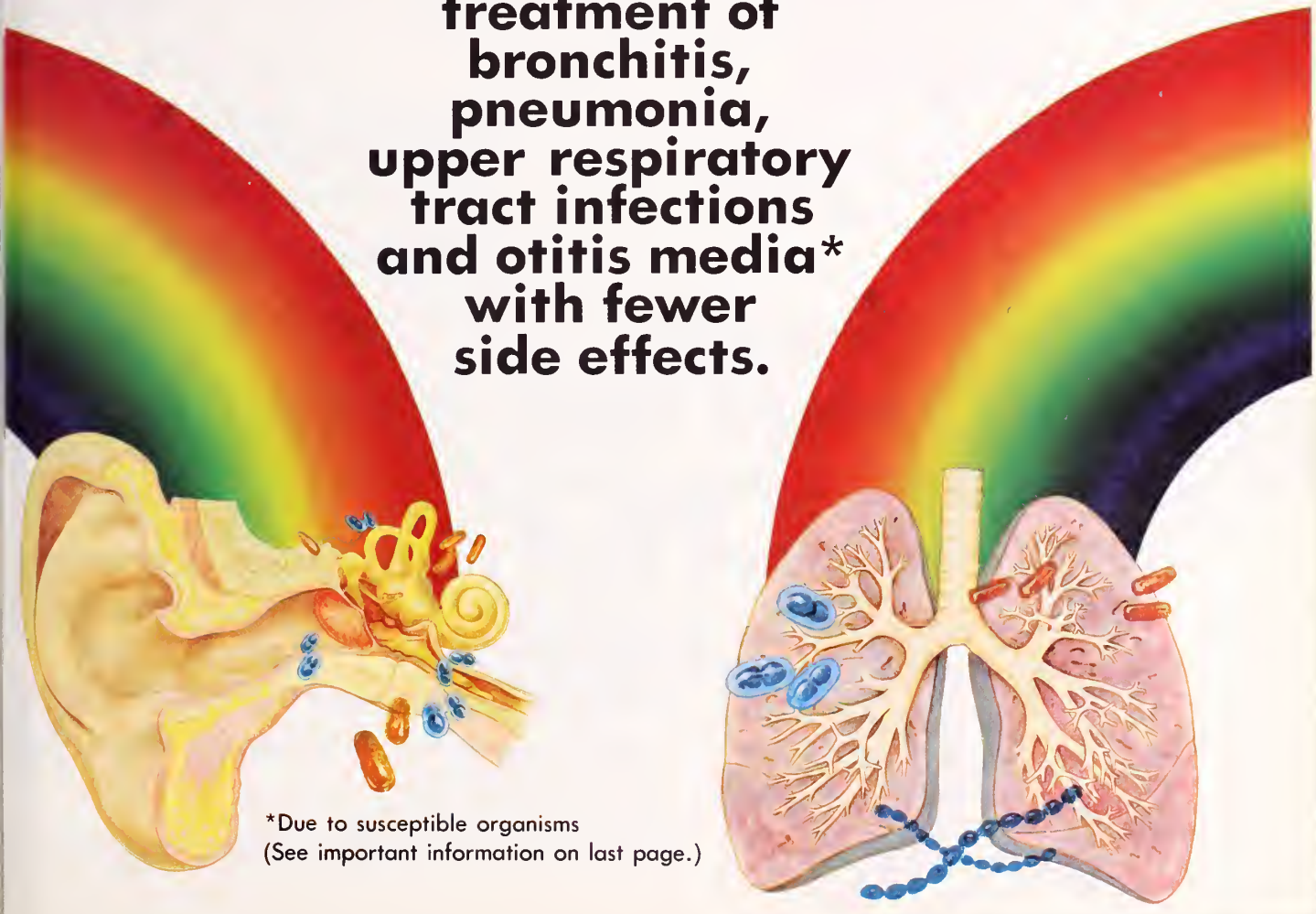
# more than just spectrum




# New CYCLAPEN®

## (cyclacillin) Tablets/ Suspension

**Efficacy proven in the treatment of bronchitis, pneumonia, upper respiratory tract infections and otitis media* with fewer side effects.**



*Due to susceptible organisms
(See important information on last page.)

# New CYCLAPEN®

## (cyclacillin) Tablets/ Suspension

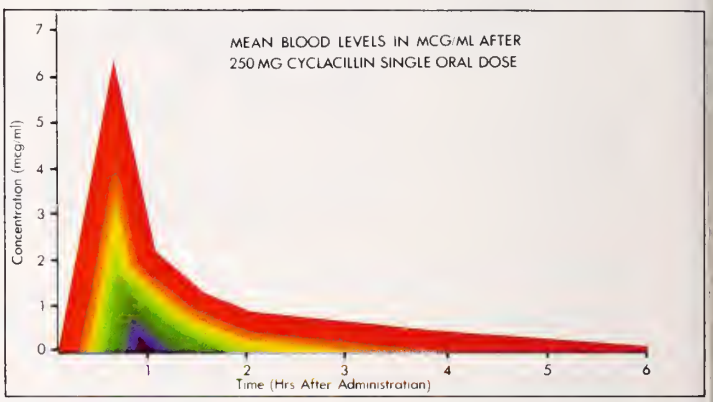
# efficacy with fewer side ampicillin confirmed in studies of 2,581

Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin




| High cure rate with CYCLAPEN® | | |
|---|---|---|
| Causative Organism | Bronchitis/Pneumonia† | No. of Patients |
| *S. pneumoniae* | 100 | 73 |
| | 95 | |
| Chronic Bronchitis† (acute exacerbation) | | |
| *H. influenzae* | 92 | 12 |
| | Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H influenzae* | |
| Streptococcal Sore Throat† | | |
| Group A beta-hemolytic Streptococcus | 100 | 44 |
| | 86 | |
| % Clinical Response | | |
| % Bacterial Eradication | | |

## more than just spectrum in bronchitis, pneumonia and upper respiratory tract infections†

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

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# effects than double-blind patients*

ewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

| Total number of drug-related side effects in all patients | |
|---|---|
| CYCLAPEN® | 128 of 1,286 (10%) of patients |
| ampicillin | 202 of 1,129 (18%) of patients |
| Difference statistically significant (P <0.001) | |

CYCLAPEN® (cyclacillin)
effective for bronchitis, pneumonia, and upper respiratory tract infections†

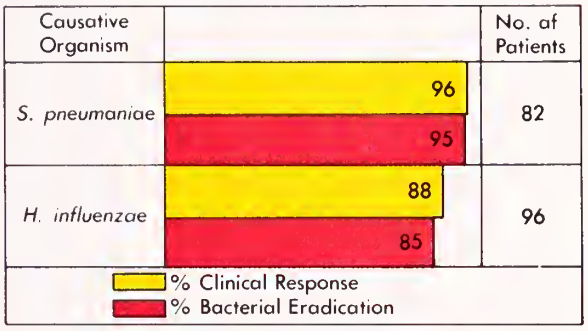
- Excellent clinical results in bronchitis, pneumonia and upper respiratory tract infections
- Significantly lower incidence of diarrhea and skin rash


. Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.

†. Data on file, Wyeth Laboratories.


## more than just spectrum in otitis media

Clinical efficacy of CYCLAPEN® in otitis media†




# more than just spectrum CYCLAPEN®

(cyclacillin) Tablets/ Suspension

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Philadelphia, Pa 19101

See important information on next page)

New from Wyeth Laboratories

# CYCLAPEN®

(cyclacillin) Tablets/ Suspension

## more than just spectrum in bronchitis, pneumonia, upper respiratory tract infections and otitis media*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

### How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

**Indications**

*Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below*

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT

Tonsilitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

**Contraindications**

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

**Warnings**

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

**Precautions**

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

**Adverse Reactions**

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

**Dosage and Administration**

| INFECTION* | ADULTS | CHILDREN |
|---|---|---|
| | | Dosage should not exceed in a dose higher than that for adults |
| *Respiratory Tract* | | |
| Tonsilitis & Pharyngitis** | 250 mg q.i.d. in equally spaced doses | body weight <20 kg (44 lbs) 125 mg q.i.d. equally spaced doses<br>body weight >20 kg (44 lbs) 250 mg q.i.d. equally spaced doses |
| Bronchitis and Pneumonia | | |
| Mild or Moderate Infections | 250 mg q.i.d. in equally spaced doses | 50 mg/kg/day q.i.d. equally spaced doses |
| Chronic Infections | 500 mg q.i.d. in equally spaced doses | 100 mg/kg/day q.i.d. equally spaced doses |
| *Otitis Media* | 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity | 50 to 100 mg/kg/day equally spaced doses depending on severity |
| *Skin & Skin Structures* | 250 mg to 500 mg q.i.d. in equally spaced doses depending on severity | 50 to 100 mg/kg/day equally spaced doses depending on severity |
| *Urinary Tract* | 500 mg q.i.d. in equally spaced doses | 100 mg/kg/day in equally spaced doses |

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

*Patients with Renal Failure*

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive half doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of <10 ml/min or serum creatinine values of >10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

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# WVU Medical Center
# —News—

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## Answers In Immunobiology Of Cancer Found

Extensive investigations are providing some basic answers concerning the immunobiology of cancer, according to the Director of Otolaryngic Research.

Robert W. Veltri, Ph. D., who is also Professor of Microbiology and Otolaryngology in the School of Medicine, said that ongoing research on three types of cancer is demonstrating several relationships between the immune reaction and the presence of malignancies.

Doctor Veltri's current research areas include investigations of the role of the Epstein-Barr virus (EBV) in malignant processes, the diagnostic and prognostic potential of tumor-related antigens in lung cancer, and the immune status of patients with head and neck cancer.

Doctor Veltri, who received his master's degree and doctorate in microbiology from WVU, has been associated with otolaryngic research for the past 10 years, working in such areas as ear diseases, head and neck cancer and tonsil immunology.

### Foundation Established

His laboratory was established by Dr. Philip M. Sprinkle, Chairman of the Department of Otolaryngology, and is largely maintained through departmental and institutional grants. The WVU Cancer Foundation for Otolaryngology Research recently was established to receive and administer specified gifts.

Doctor Veltri's research with EBV concerns its role in the immune status of patients with cancer of the lymph system, primarily Hodgkins disease. "In this work we are collaborating with Dr. Peter Raich, Chairman of the Department of Medicine's Section of Hematology and Oncology," he said.

Work is still continuing under Doctor Veltri's direction on the lung cancer antigen research program. Begun in 1974 under a four-year National Cancer Institute contract of $426,000, the interdisciplinary study resulted in the isolation and identification of two "markers" of lung cancer.

Studies on head and neck cancer patients have implicated two factors which contribute to impaired natural immunity. Immune suppression in these patients has been confirmed by laboratory tests at the time of diagnosis and during and following treatment.

Doctors Veltri, Sprinkle and Dr. Cedric Quick, Professor of Otolaryngology, have found that nutrition has a direct bearing on immune response. Also impairing natural resistance in these patients is a circulating immune complex in their blood described by Doctor Veltri as an unknown antigen bonded to an antibody.

## Fourteen Students Elected To Honor Society

Fourteen senior and junior medical students have been elected to membership in Alpha Omega Alpha honor medical society.

The eight seniors chosen are Chris Byard, Huntington; John England, Nutter Fort; Daniel Harrington, Beckley; Terry Koubek, South Charleston; Richard Layne and Jeffrey Stambaugh, Williamson; David Pitrolo, Fairmont, and Tony Zerbe, Washington.

Third-year students elected are Susan Bonfili, Morgantown; Lloyd Cantley, Big Chimney; Thomas Croghan and Kyle Strader, Clarksburg; Deborah Dickert, South Charleston, and Roberta E. Galford, Weston.

One faculty member and two School of Medicine alumni were also chosen for membership by the AOA chapter at WVU. They are Dr. Irma Ullrich, Associate Professor of Medicine, and Dr. William Neal, Associate Professor of Pediatrics and Pediatric Cardiology Section Chief, and Dr. Joseph Renn III, Clinical Associate Professor of Medicine.

James K. Porterfield, a senior from Martinsburg, is President of the WVU chapter.

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  Pays you a regular weekly benefit up to $500 per week when you are disabled.
- ☐ $30,000 MAJOR HOSPITAL PLAN
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- ☐ HOSPITAL MONEY PLAN
  Pays you up to $100.00 per day when you or a member of your family is hospitalized
- ☐ LOW-COST LIFE INSURANCE
  In units of — $10,000 — $20,000 — $30,000 — $40,000 — $50,000
- ☐ $100,000 ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
  Around the clock protection — 24 hours a day . . . 365 days a year . . . worldwide
- ☐ OFFICE OVERHEAD DISABILITY POLICY
  Pays your office expense up to $3,500 per mo. while you are disabled
- ☐ A MILLION DOLLAR CATASTROPHE LIABILITY POLICY
  Covers: Malpractice — Home — Personal — Auto Liability

Name _____

Address _____ Phone # _____

# Third-Party News, Views and Program Concerns

## Compensation Fund Designs New Disability Card

The State Workmen's Compensation Fund has designed a new card to be used by physicians who regularly treat the severely industrially disabled. The card should be used for spinal cord injuries, amputations, brain stem injuries, severe burns and other conditions that will obviously result in a minimum of six months of disability.

The purpose of the card is two-fold. Primarily, it will eliminate the need for the doctor to complete an Attending Physician's Report (WC-219) every two to three months when it is known that the disability period will last much longer. Also, since the card should be sent to the Fund as soon as long-term disability becomes apparent, it will help the Fund identify severely-injured claimants so that individual case management can be provided much earlier.

The Fund's practice of scheduling a claimant for a maximum of three months' disability benefits at a time is necessary in most cases in order to monitor the claim properly. This card, however, will allow the few claimants with long-term disabilities to be scheduled for either six or 12 months of continuous temporary total disability payments. The card is *not* a substitute for more complete information. Depending upon the medical information available in the claim file, the Fund may request a detailed medical report.

Since the majority of lost-time claims are paid and closed in less than three months, the new card will not be available through regular ordering procedures, but will be distributed to those physicians whose specialties bring them in contact with the more severely injured. For further information about this card, please contact the Rehabilitation Services Division, Workmen's Compensation Fund, 112 California Avenue, Charleston 25305.

Name _____ Claim No. _____
Social Security No. _____ Date of Injury _____

Due to the condition indicated below, this claimant will be disabled a minimum of ☐ 6 months ☐ 12 months from the current date.

☐ Spinal Cord Injury ☐ Brain Stem Injury
☐ Amputation ☐ Burns
☐ Operative Procedure (Type) _____
☐ Other (please specify) _____

Physician's Name & Address Physician's Telephone Number

Physician's Signature _____ Date _____

**New physicians' card designed by State Workmen's Compensation Fund.**

## New Disability Evaluation Handbook Available

A handbook of revised medical criteria for evaluating disability in adults filing for benefits under the Federal Social Security and Supplemental Security Income programs is now available for physicians and allied medical personnel. Entitled *Disability Evaluation Under Social Security: A Handbook for Physicians*, this handbook provides over 100 sets of symptoms, signs, and laboratory findings to help evaluate impairments.

Both disability programs are administered by the Federal Social Security Administration (SSA). A Disability Determination Section in each state makes the disability determinations for its residents using these national criteria under the direction and monitoring of SSA.

Physicians may receive a free copy of this handbook by writing Victor B. Clark, Medical Relations Officer, or Dr. William S. Herold, Chief Medical Consultant, West Virginia Disability Determination Section, 1206 Quarrier Street, Charleston 25301, or by calling 304-348-5340, extension 35.

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Samuel A. Strickland, M.D.

**E.E.N.T.**
John B. Haley, M.D.
John A. B. Holt, M.D.

**OTOLARYNGOLOGY**
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ARGON LASER PHOTOCOAGULATION
STRONTIUM 90 BETA IRRADIATION
ORTHOPTICS
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HEAD AND NECK SURGERY
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M. C. Rosenberg, D. O. (Helvetia Clinic)
L. E. Soriano, M. D. (Marlinton Clinic)
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**Allergy & Rheumatology:**
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**Cardiology:**
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P. W. Gregor, M. D.
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**Pulmonary Diseases:**
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J. J. Rizzo, M. D.

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W. B. Blum, M. D.
B. R. Blackburn, M. D.

**UROLOGY:**
D. T. Chua, M. D.

# Obituaries

### WILLIAM D. McCLUNG, M. D.

Dr. William D. McClung of Lewisburg, a general practitioner and surgeon, died on February 8 in a Ronceverte hospital. He was 63.

Doctor McClung had practiced in Lewisburg for six years. He previously practiced in Richwood where has was associated with the former McClung Hospital.

Doctor McClung was a Past President of the West Virginia Chapter, American College of Surgeons, and a past member of the West Virginia Board of Health.

He was graduated from Marshall University and received his M. D. degree in 1940 from the University of Maryland School of Medicine.

Doctor McClung completed a three-year surgical residency at Mercy Hospital in Baltimore, and a one-year surgical fellowship at Lahey Clinic in Boston.

A veteran of World War II (Navy), he was an honorary member of the Greenbrier Valley Medical Society, West Virginia State Medical Assocation and American Medical Association.

Survivors include the widow; three sons, Andrew and Charles McClung, both of Lewisburg, and James McClung of Miami, Florida; four sisters, Beatrice McClung of Charleston, Mrs. Kathryn Welch of Lewisburg, Mrs. Margaret Johnson of Rupert, and Mrs. Ruth Nellen of Green Bay, Wisconsin.

* * *

### CORNELL L. PANOVICIU, M. D.

Dr. Cornell L. Panoviciu, retired physician and former Clinical Director at the Roney's Point Center, West Virginia Department of Mental Health, in Triadelphia, died on February 23 in a Wheeling Hospital. He was 70.

A resident of Wheeling, he had practiced in that city from 1971 until his retirement in 1977.

Surviving are several friends, among whom are Mr. and Mrs. Gene Rose of Cambridge, Ohio; Mr. and Mrs. Paul Hamilton of Wheeling, and Sister Hildegarde Uttermohlen, SSJ, Wheeling.


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# County Societies

### FAYETTE

The Fayette County Medical Society held its January meeting at Montgomery General Hospital. The guest speaker was Dr. Stafford G. Warren of Charleston, who discussed new methods of non-invasive cardiac diagnosis.

The Society met again on February 6 at Oak Hill Hospital. Dr. Syed Rasheed of Beckley spoke on "Changing Concepts in Management of Diabetes Mellitus."

There was discussion on possible service projects the Society might undertake, and establishment of a committee for handling complaints about medical care.—Daniel B. Doyle, M. D., Secretary.

* * *

### CABELL

The Cabell County Medical Society met on February 14 at the Gateway Inn in Barboursville.

Dr. Robert W. Coon, substituting for the guest speaker who was unable to attend, gave a status report on the Marshall University School of Medicine, and discussed the admissions process and the makeup of the Admissions Committee. Doctor Coon is MU Vice President for Health Sciences and School of Medicine Dean.

Drs. William S. Sadler and Harry K. Tweel were elected to serve on the Medical School Advisory Board.

Dr. Charles E. Turner presented recently-typed Society minutes dating from the founding of the Society in 1891 through 1923. The minutes were typed by Ms. Kay Gibson, Head Librarian at St. Mary's Hospital. — Charles E. Turner, M. D., Secretary.

* * *

### MARION

Dr. K. Douglas Bowers, Jr., of Morgantown was the guest speaker for the meeting of the Marion County Medical Society on February 26 at the Fairmont Field Club.

Doctor Bowers is Team Physician for the West Virginia Mountaineers Football Team. He discussed artificial and natural playing surfaces for football, and the injuries resulting from the use of artificial surfaces.—William L. Mossburg, M. D., Secretary.

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### McDOWELL

The McDowell County Medical Society met on February 13 at the Candlelight Restaurant in Welch.

The scientific program and dinner were hosted by John C. Whitmore. Senior Professional Representative of Merck Sharp & Dohme.

Mr. Whitmore showed a film on "Viewpoints on Degenerative Joint Diseases," a panel discussion on osteoarthritis. — Muthusami Kuppusami, M. D., Secretary.


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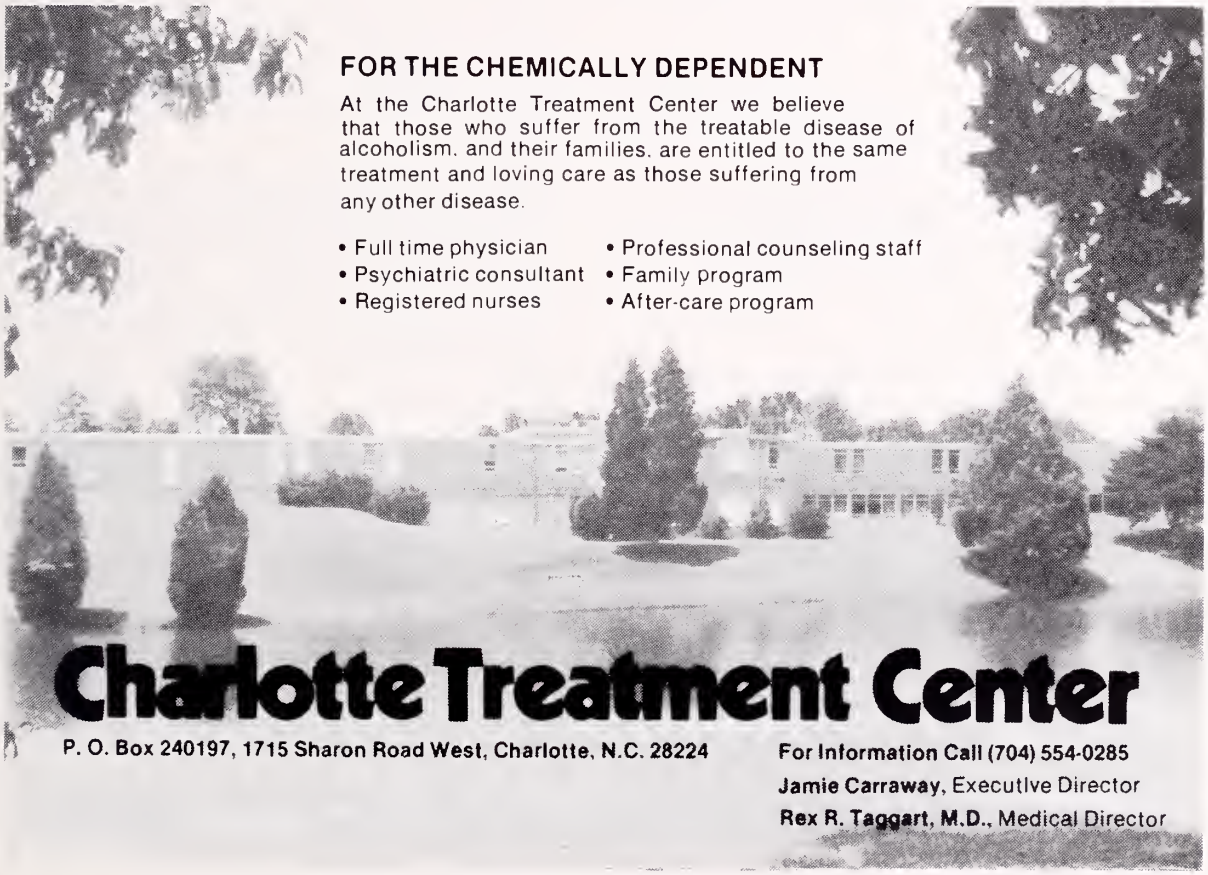

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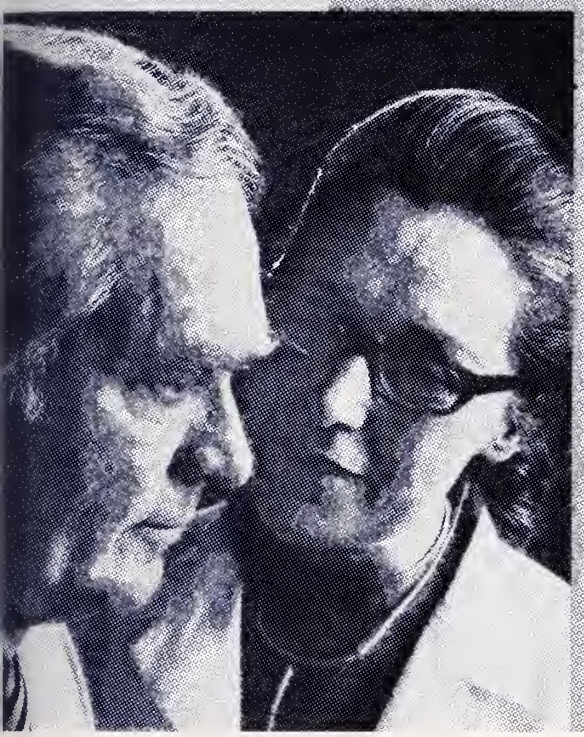

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# CONTENTS

**Scientific Articles**

Solitary Testicular Metastasis from Renal Cell Carcinoma and Concomitant Primary Adenocarcinoma of the Prostate—Gregory J. Post, M. D.; and Joseph Kassis, M. D. 99

An Outbreak of Shigellosis in Kanawha County, West Virginia—Thomas A. Horsman, M. D.; William J. Zekan; Charles W. Stratton, M. D.; and H. Bradford Hawley, M. D. 103

Primary Squamous Cell Carcinoma of the Endometrium: A Case Report—Chinmay K. Datta, M. D.; and Paul E. Gordon, M. D. 109

**Scientific Department**

Medical Grand Rounds from the West Virginia University Medical Center (A Review of Lithium)—Edited by Irma H. Ullrich, M. D. 111

**The President's Page**

Political Choice—Stephen D. Ward, M. D.; President, W. Va. State Medical Association 116

**Editorials**

Some Early Steps in A Big Effort 117
The Trainers' Bill 117

**General News**

113th Annual Meeting 119
Continuing Education Activities 121
Peer Review Statute Success 122
Eighteen New Family Physicians in State 122
MU Receives Vaccine-Evaluation Grant 123
To Review Welfare Medical Program 124

**Special Departments**

WVU Medical Center News xiv
Third-Party News, Views, Program Concerns xvi
Obituaries xviii
County Societies xix
Book Review xxi
Classified Section xxvi
Index To Advertisers xxviii

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# Perdiem™

Prescribing Information

ACTIONS. Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

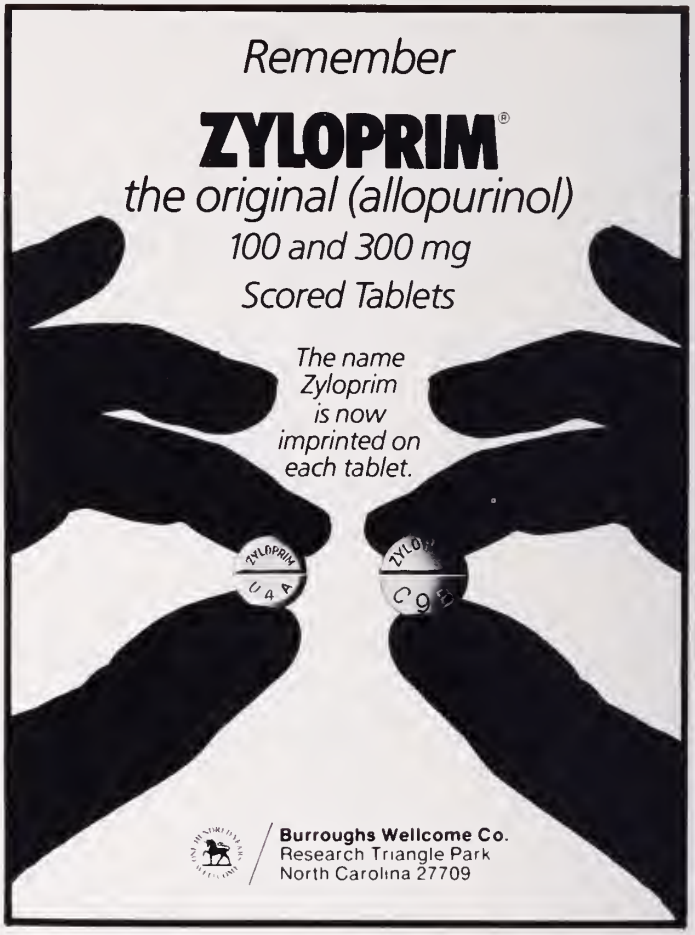
FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules: 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.

WILLIAM H. RORER, INC.
Fort Washington, PA 19034








pepi

The Physical Education Public Information (PEPI) Project is a public service campaign developed by AAHPER to inform Americans about the value and benefits of school physical education programs.

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A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

# EQUAGESIC® ℂ IV

## (meprobamate and ethoheptazine citrate with aspirin) Wyeth

**EQUAGESIC—Abbraviated Summary**

***INDICATIONS**: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.
"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

**CONTRAINDICATIONS**: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

**WARNINGS**: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e g , alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

**USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diezepam) during the first trimester of pregnancy has been suggested in savarel studies. Becausa use of these drugs is rarely a matter of urgency, thair use during this parlod should almost always ba evoided. The possibility that a woman of child-bearing potential may be pragnant at the time of institution of therapy should be considared. Patients should be advised that if they become pregnant during therapy or intand to becoma pregnant they should communicate with thair physicians about the desirability of discontinuing the drug.**
**Meprobamate passes the placentel berrier. It is present both in umbilical-cord blood at or near meternal plasma levels and in breast milk of lacteting mothers et concantretions two to four times that of maternal plasma. When use of meprobamate is contemplatad in braast-feeding patients, the drug's higher concantrations in breast milk as compared to maternel plasma levels should be considared.**
Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

**PRECAUTIONS**: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously edministered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

**ADVERSE REACTIONS**: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.
Impairment of accommodation and visual acuity has been reported rarely.

**OVERDOSE**: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

**DESCRIPTION**: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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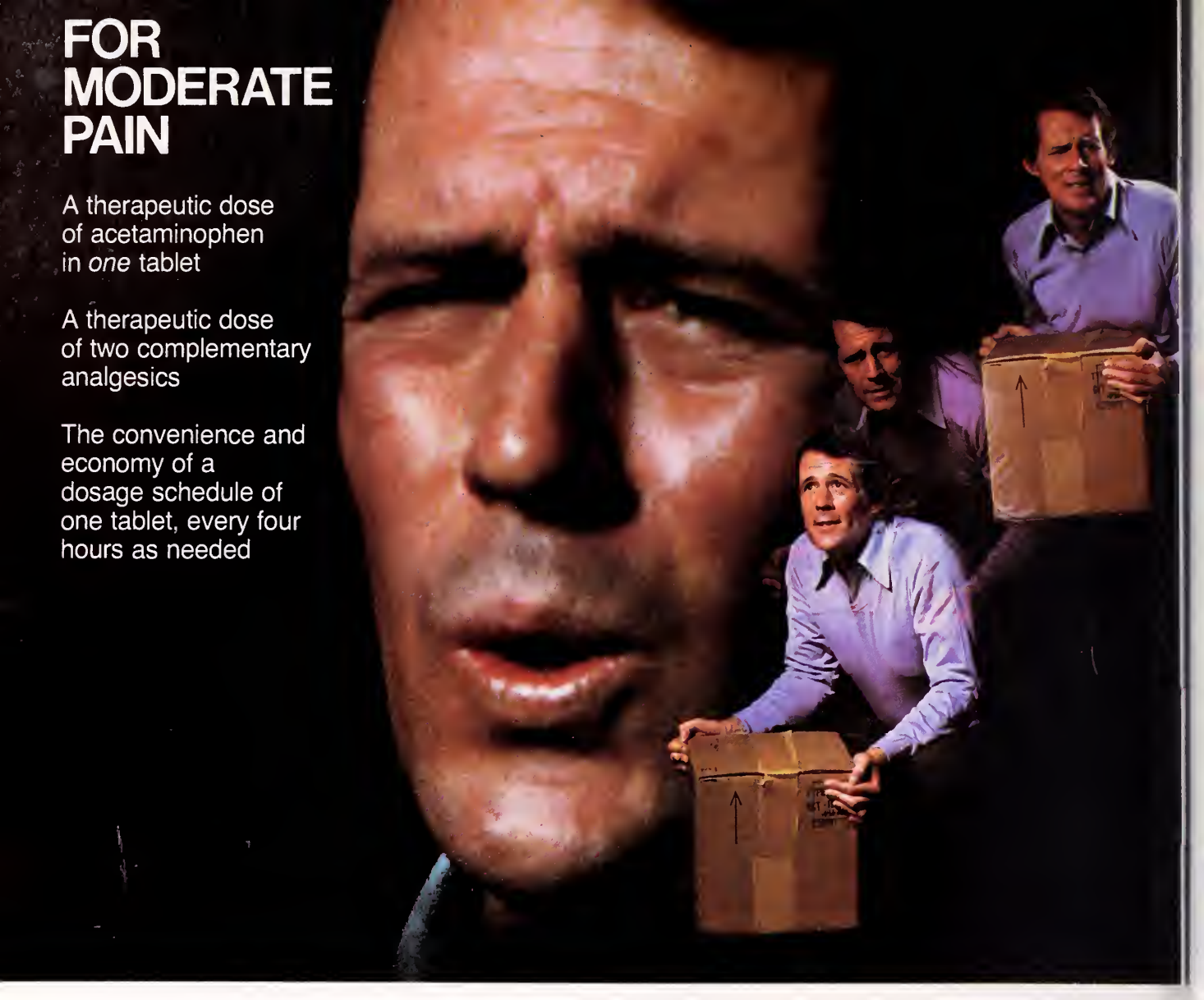
*This drug has been evaluated as possibly effective for this indication.

**Wyeth Laboratories**
Philadelphia, Pa 19101




# WHY NOT WYGESIC® CIV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

**WYGESIC—Abbreviated Summary**

**INDICATION**: For the relief of mild-to-moderate pain.

**CONTRAINDICATION**: Hypersensitivity to propoxyphene or to acetaminophen.

**WARNINGS**: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

**DRUG DEPENDENCE**: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

**USAGE IN AMBULATORY PATIENTS**: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

**USAGE IN PREGNANCY**: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

**USAGE IN CHILDREN**: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

**PRECAUTIONS**: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

**ADVERSE REACTIONS**: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

**DRUG INTERACTIONS**: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

**MANAGEMENT OF OVERDOSAGE**: SYMPTOMS: The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

**TREATMENT**: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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**Wyeth Laboratories**
Philadelphia, Pa 19101

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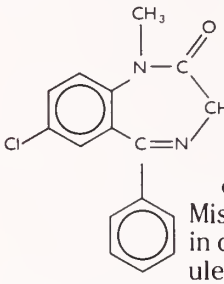
*Aspects of Management*

# What to tell your patients when you prescribe Valium® (diazepam/Roche)

## Survey shows significant correlation between comprehension and compliance




A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.* Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy. Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

## What Valium (diazepam/Roche) can do

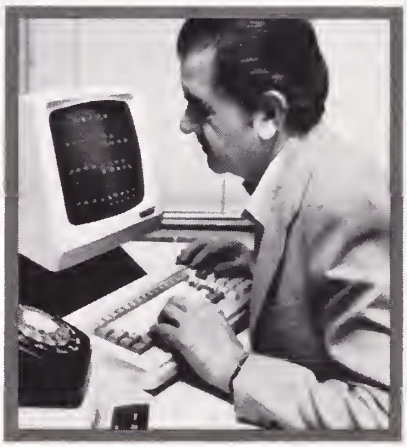
Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms. Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.



## What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, *et al*: *Am J Hosp Pharm 31*: 485-491, May 1974

**Before prescribing, please consult complete product information, a summary of which follows:**

**Indications:** Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics,

# Practical pointers on taking antianxiety medications

**do's** Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects. Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

**and don'ts** Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

*2-mg, 5-mg, 10-mg scored tablets*

# Valium® IV

## diazepam/Roche

## An important adjunct to your treatment program for excessive psychic tension

barbitu-
ates, MAO
nhibitors and
other antidepres-
sants may potentiate
its action. Usual precautions indicated in patients
severely depressed, or with latent depression, or with
suicidal tendencies. Observe usual precautions in impaired renal or hepatic function.
Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or
oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults.* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients.* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children.* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

**Supplied:** Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

ROCHE®

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**OPTIMINE®**
azatadine maleate, 1 mg tablets

**CONTRAINDICATIONS** Use in Newborn or Premature Infants This drug should not be used in newborn or premature infants

Use in Nursing Mothers Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers

Use in Lower Respiratory Disease Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section)

**WARNINGS** Antihistamines should be used with considerable caution in patients with narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction

Use in Children In infants and children especially antihistamines in overdosage may cause hallucinations, convulsions, or death

As in adults, antihistamines may diminish mental alertness in children In the young child, particularly they may produce excitation

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE

Use in Pregnancy Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus

Use with CNS Depressants Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc )

Use in Activities Requiring Mental Alertness Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery etc

Use in the Elderly (approximately 60 years or older) Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined

*General* Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat

*Cardiovascular System* Hypotension, headache, palpitations, tachycardia, extrasystoles

*Hematologic System* Hemolytic anemia, thrombocytopenia, agranulocytosis

*Nervous System* Sedation sleepiness dizziness, disturbed coordination fatigue, confusion restlessness, excitation, nervousness, tremor, irritability insomnia euphoria paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

*Gastrointestinal System* Epigastric distress anorexia, nausea, vomiting diarrhea constipation

*Genitourinary System* Urinary frequency, difficult urination urinary retention, early menses

*Respiratory System* Thickening of bronchial secretions, tightness of chest and wheezing nasal stuffiness

**OVERDOSAGE** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation Stimulation is particularly likely in children Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur

If vomiting has not occurred spontaneously, the patient should be induced to vomit This is best done by having him drink a glass of water or milk after which he should be made to gag Precautions against aspiration must be taken, especially in infants and children

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand Isotonic and . isotonic saline is the lavage solution of choice

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content

Stimulants should not be used

Vasopressors may be used to treat hypotension

FEBRUARY 1977 11055010

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# An added complication... in the treatment of bacterial bronchitis*

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**Indications and Usage:** Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindication:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

*Usage in Pregnancy*—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

*Usage in Infancy*—Safety of this product for use in infants less than one month of age has not been established.

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

*Hepatic*—Slight elevations in SGDT, SGPT, or alkaline phosphatase values (1 in 40).

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

**Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

*Note:* Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References**


1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.


*Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285*

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# Solitary Testicular Metastasis From Renal Cell Carcinoma And Concomitant Primary Adenocarcinoma Of The Prostate

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*The thirteenth case of renal cell carcinoma with testicular metastasis (with only 12 cases heretofore reported in the English literature) is presented. To our knowledge this is the first such case presenting with a concomitant adenocarcinoma of the prostate. Diagnosis and treatment considerations are discussed.*

Renal cell carcinoma often presents with bizarre symptoms and signs due to early tumor metastasis and to late diagnosis of the primary lesion. It is for this reason that Creevy wrote, "Malignant renal tumors should be classified with syphilis and tuberculosis as among the great mimics encountered in clinical medicine."[1] Single metastatic lesions are not uncommon with renal cell carcinoma, in contrast to other carcinomas where metastases are generally widespread.[2] Solitary testicular metastases are exceedingly rare with only 12 cases reported in the English literature. We present the first case of a solitary testicular metastasis from renal cell carcinoma with simultaneous primary adenocarcinoma of the prostate.

### Case Report

A 64-year-old, white male was admitted to the Clarksburg, West Virginia, Veteran's Administration Center with a three-day history of mild dysuria, nausea, and low-grade fever. He had no prior genitourinary complaints and was in excellent physical health prior to admission. Physical examination revealed no abdominal tenderness or masses. A firm, two-centimeter nodule was palpable in the upper pole of the left testis. The right testicle was normal. On rectal examination, a discrete, hard, one-centimeter nodule was palpated in the left lobe of the prostate. Laboratory studies, including hemogram, serum chemistry profile, and electrolytes, were within normal limits. Urinalysis demonstrated 5-10 WBC's/HPF, and urine culture grew 100,000 colonies of Enterobacter cloacae sensitive to all antibiotics tested. The patient was placed on Trimethoprim-sulfamethoxazole therapy. The fever, nausea and dysuria promptly resolved.

Intravenous urogram demonstrated bilateral prompt renal function. There was a mass lesion in the upper pole of the left kidney. Left renal arteriography confirmed an 8 x 10-centimeter vascular mass consistent with renal cell carcinoma. Bone scan, liver-spleen scan, and whole lung tomograms were negative for metastasis.

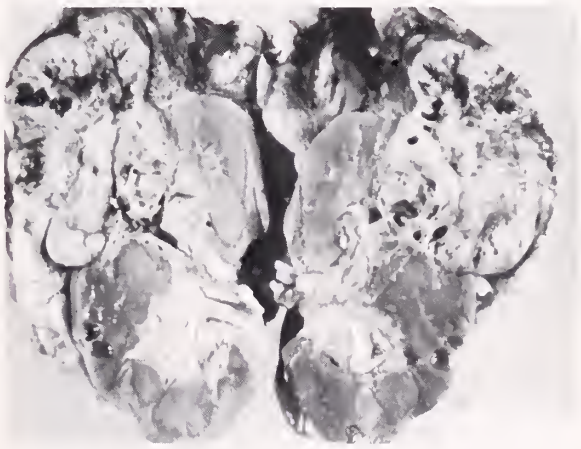

**Figure 1. Left upper pole renal mass with extension into perinephric fat.**

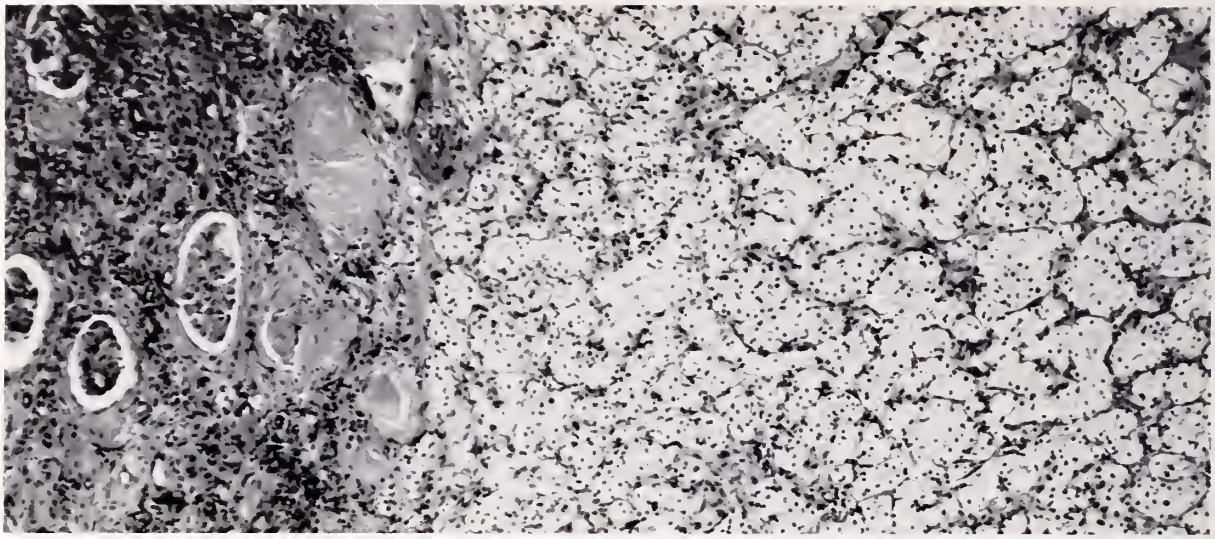

**Figure 2. Clear cell carcinoma with capsular invasion (H & E, X100).**

A transabdominal left radical nephrectomy was performed. A well-demarcated, eight-centimeter tumor was found in the superio-lateral portion of the upper pole (Figure 1). Pathology diagnosis was clear cell renal cell carcinoma with capsular and perinephric fat invasion (Figure 2). The renal vessels were free of tumor infiltration.

Postoperatively, the patient did extremely well. A transrectal needle biopsy of the prostate was performed. The tissue obtained from the prostatic nodule demonstrated well-differentiated adenocarcinoma of the prostate.

Fourteen days after the radical nephrectomy a left inguinal orchiectomy was performed. A one-centimeter nodule was found in the upper pole of the left testicle (Figure 3). This was composed of sheets of clear cells with central and eccentric nuclei consistent with metastatic renal cell carcinoma (Figure 4).

Because of the presence of metastatic renal cell carcinoma, radical surgery for the prostatic carcinoma did not seem to be justified. Hormonal treatment was discussed as a possible means of adjunctive therapy, and a right scrotal orchiectomy was performed.

The patient is doing well six months postoperatively. Follow-up chest x-ray and bone scan remain normal. There has been no palpable change in the prostatic nodule.

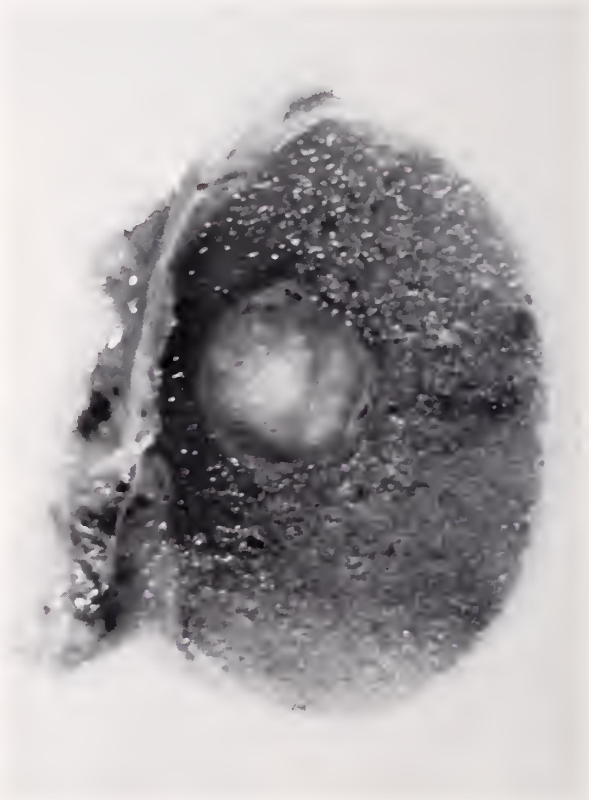

**Figure 3. Cross section of left testicle demonstrating metastatic nodule.**

### Discussion

The silent nature of renal cell carcinoma as well as the variable signs and symptoms caused by distant metastases is well recognized. At least 30 per cent of patients with renal cell carcinoma have evidence of metastases when first seen.[3] The most common sites of metastatic involvement are lung, bone, liver, lymph node, and brain.[4] Testicular metastases are extremely rare, since only 12 cases have been reported in the English literature.[5,6] Pienkos and Jablokow reviewed approximately 24,000 autopsies and found only one case of renal cell carcinoma with testicular metastases.[6]

**Figure 4. Metastatic renal cell carcinoma with normal testicular tubules at right margin (H & E, X100).**

Solitary distant metastases occur in one to three per cent of patients with renal cell carcinoma.[7] These most frequently occur by vascular dissemination.[3] The most likely route of left renal cell carcinoma metastasis to the testicle is via the left internal spermatic vein. From a surgical standpoint it is advisable to mobilize and divide the left spermatic vein at a low level when removing the kidney for carcinoma.[8]

Although an asymptomatic testicular nodule was found in this instance, painful testicular swelling can also herald the presence of an underlying malignancy. Bandler and Roen reported a case of metastatic right testicular mass producing pain and swelling which preceded the diagnosis of right renal cell carcinoma by over two years.[2] Thorough physical examination with careful palpation of the scrotal contents is indicated in all patients. The presence of a varicocele or a testicular nodule may help to establish the diagnosis of an underlying renal malignancy.

Multicentric transitional cell carcinoma of the urothelium is well known as opposed to multiple primary adenocarcinomas. Villegas reported a case of transitional cell carcinoma of the left renal pelvis associated with right renal cell carcinoma and primary adenocarcinoma of the prostate.[9] That patient, who also had multiple pulmonary metastases, died of a myocardial infarction. An unusual case of multiple adenocarcinomas arising from the kidney, bladder, and prostate was reported by Das and Brosman.[10] Their patient had no evidence of metastatic disease and underwent a staged radical nephrectomy and radical cystectomy. He was alive and well 12 months postoperatively.

The probability of developing additional metastases after removal of a solitary renal cell carcinoma metastasis is great. Middleton described a 34 per cent five-year survival after removal of a solitary metastasis in 59 cases of renal cell carcinoma.[11] Even without metastases at the time of nephrectomy, the five-year survival for Stage III renal cell carcinoma is 47 per cent, and the ten-year survival is 20 per cent.[12] These statistics were taken into account before a radical prostatectomy was considered in our patient. Radical prostatectomy for a well-differentiated Stage B lesion did not appear to be justified in this case.

The variable symptoms and signs produced by renal cell carcinoma make it manditory for the physician to perform a thorough history and physical examination in all patients. The possibility of multicentric genitourinary tumors must always be kept in mind during patient evaluation. The early diagnosis and management of such a patient presents a unique challenge to the practicing urologist.

### References


1. Creevy CD: Confusing clinical manifestations of malignant renal neoplasms. *Arch Int Med* 55:895, 1935.

2. Bandler CG, Roen PR: Solitary testicular metastasis simulating primary tumor and antedating clinical hypernephroma of the kidney. *J Urol* 55:663, 1946.

3. Chute R, Ireland EF, Houghton JD: Solitary distant metastasis from unsuspected renal carcinoma. *J Urol* 80:420, 1958.

4. Nalle BL: Distant metastases of 58 renal neoplasms. *J Urol* 57:662, 1947.

5. Willis RA: *The Spread of Tumors in the Human Body*, ed 2, London, Butterworth and Company, Ltd, 1952.

6. Pienkos EJ, Jablokow VR, Secondary testicular tumors. *Cancer* 30:481, 1972.

7. Tolia BM, Whitmore WF: Solitary metastasis from renal cell carcinoma. *J Urol* 114:836, 1975.

8. Hanash KA, Carney JA, Kelalis PP: Metastatic tumors of the testicles: Routes of metastasis. *J Urol* 102:465, 1969.

9. Villegas AC: Bilateral primary malignant renal tumors of dissimilar histogenesis: Report of two cases and review of the literature. *J Urol* 98:450, 1967.

10. Das S, Brosman SA: Multiple primary adenocarcinomas of the urogenital tract. *Urol* 8:277, 1976.

11. Middleton RG: Surgery for metastatic renal cell carcinoma. *J Urol* 97:973, 1967.

12. Skinner DG, Vermillion CD, Colvin RB: The surgical management of renal cell carcinoma. *J Urol* 107:705, 1972.

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# An Outbreak of Shigellosis In Kanawha County, West Virginia

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*An outbreak of shigellosis in Kanawha County, West Virginia, during the summer of 1977 is described. This disease has been reported infrequently in both the county and state. The clinical and laboratory diagnosis of shigellosis and the treatment of shigellosis are reviewed.*

In 1898, Shiga reported that he had isolated a similar strain of bacteria from 34 patients with dysentery; this organism and others of the same genus now bear his name.[1] The shigella organisms have since been divided into four groups and approximately 50 serotypes by virtue of specific cell wall antigens. Each group has one important species: (A.) *Shigella dysenteriae*, (B.) *Shigella flexneri*, (C.) *Shigella boydii*, and (D.) *Shigella sonnei*. *Shigella sonnei* is the most frequently isolated species in the United States.[2]

Physicians in the United States tend to think of shigellosis as an uncommon disease. Epidemiologic investigators have shown that a low standard of sanitation determines the incidence of shigella infection.[3] Despite an overall high standard of sanitation, the United States reported 7,907 cases of shigellosis in 1976.[4] Clusters of cases have occurred in homes for the retarded, [4,5] in Indian reservations, [6] and in day care centers.[7] We are reporting an outbreak of shigellosis from a rural section of Kanawha County, West Virginia, which occurred during the summer of 1977. In addition, the literature concerning this disease is reviewed, emphasizing clinical illness, laboratory diagnosis, and therapy.

### Materials and Methods

On July 25, 1977, an 18-year-old woman (Case 1) was admitted to General Division, Charleston Area Medical Center and found to have shigellosis. The patient reported that members of her family and also neighbors had been experiencing a similar illness. Members of the Section of Infectious Diseases at the Charleston Division of West Virginia University Medical Center and the Kanawha County Health Department visited the patient's home and surrounding area. Family members and neighbors were questioned and, in some cases, examined and cultured. Specimens for culture were either stools or rectal swabs which were promptly inoculated onto xylose-lysine-deoxycholate agar (XLD), Hektoen agar, MacConkey's agar, mannitol salts agar, and gram-negative broth. Any nonlactose fermenting colonies were then biochemically identified using API-20E (Analytab Products Incorporated, Plainview, New York) method. Any isolates presumptively identified as shigella were sent to the West Virginia State Hygienic Laboratory for serologic confirmation.

Environmental cultures were also obtained. Water specimens from a well used by the index case and her family, a spring running nearby the family house, an outhouse, and the creek (Billy Branch) in front of the family dwelling (Figure 1) were collected in approximately one-liter quantities. Each water sample was passed through a 0.45 micron Millipore filter and the back side of the filter pressed onto the surface of both XLD and Hektoen agar plates. Bacteria were identified using API methodology.

Approximately one month later another case (Case 2) of shigellosis was identified from a patient in a nearby locality, and a similar investigation as previously described was undertaken. Finally, a third focus of infection became apparent when another patient was discovered from yet a third nearby section. The patient and the area were also surveyed.

### Results

*Case* 1. A. W., an 18-year-old, Caucasian woman, was first seen in the Emergency Room of the General Division of the Charleston Area Medical Center on July 25, 1977. She had a one-day history of lower abdominal pain, diarrhea, and fever. At that time her temperature was noted to be 39°C. Examination of her abdomen revealed right lower quadrant tenderness without rebound tenderness; pelvic and rectal examinations were reported to be normal. She

was admitted for observation with a diagnosis of possible appendicitis.

Laboratory data revealed a white blood count of 11,500/cu.mm with 85 per cent neutrophils and five per cent bands. Urinalysis, serum electrolytes, chest and abdominal roentgenograms were normal. A urine culture was negative. Two stool cultures obtained on the day following admission grew *S. sonnei*, sensitive to all antibiotics tested.

The patient was treated with ampicillin, 500 mg. four times a day for five days. She became afebrile after 24 hours of therapy; however, diarrhea persisted for five days.

*Case* 2. B. N., a 28-year-old, Caucasian woman, was seen in the Emergency Room of the General Division of the Charleston Area Medical Center on August 20, 1977. She complained of watery diarrhea, nausea, vomiting, lower abdominal cramping, fever of 40°C, and shaking chills over the preceding 24 hours. Examination revealed lower abdominal tenderness, a large amount of vaginal discharge and questionable right and left bilateral adnexal tenderness. She was admitted with a presumptive diagnosis of pelvic inflammatory disease.

Laboratory data revealed white blood count of 13,300/cu.mm. with 66 per cent neutrophils and 34 per cent bands. Serum chemistries were all normal except for potassium of 2.5 mEq/liter. The urinalysis was normal. A Gram stain of the stool showed many neutrophils. Cultures of the urine and blood were negative. Cervical culture was negative for gonococci. Stools for ova and parasites were negative; however, a rectal swab culture grew *S. sonnei*. The patient was treated with oral ampicillin, 500 mg. four times a day for five days. The temperature remained elevated for five days with persistence of diarrhea for four days.

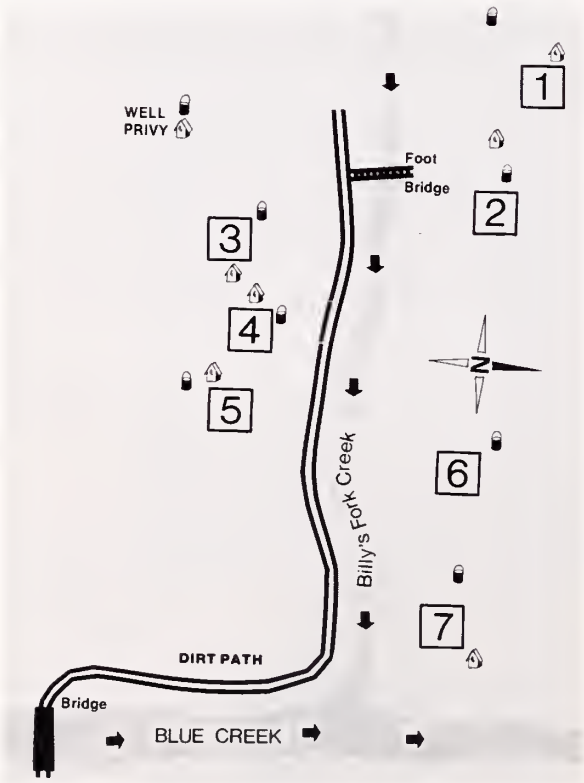


**Figure 1. Blue Creek Area.**

**Figure 2. Frame Road Area.**

Seven houses, all adjacent to Billy's Fork (Figure 1), were located in the Blue Creek area. The index case was from house two. All members of this household had diarrhea, abdominal cramps, and fever; however, only two permitted cultures taken and these both grew *S. sonnei*. In addition, house seven had seven occupants with signs and symptoms suggestive of shigellosis (Table 1). All houses, with the exception of house six, had outside toilet facilities, and all houses were served by an outside well.

**TABLE 1**

**Incidence of Symptoms in Shigellosis Patients**

| | *Number of Residents* | *Diarrhea* | *Abdominal Cramps* | *Nausea and/or vomiting* | *Fever* |
|---|---|---|---|---|---|
| Blue Creek Area | 21 | 7 | 7 | 0 | 6 |
| Frametown Road Area | 15 | 7 | 7 | 4 | 5 |
| Jordan Creek Area | 6 | 1 | 1 | 1 | 1 |

The wells were often found to be at a lower level than the privies. The soil in this area has a high clay content and was saturated from heavy rains earlier in July. Cultures of the water samples from the well, spring, and creek grew a large number of coliforms, but no shigella was isolated.

The Frame Road area (Figure 2) consisted of five houses, all of which sit adjacent to Little Sandy Creek. Only two of these dwellings had outside toilet facilities (houses eight and nine), but all had an open well as their water source. The first patient (B. N.) from this area was from house 12. All four family members from this household had symptoms of diarrhea, nausea and/or vomiting, abdominal cramps and fever. All four members permitted cultures to be taken and all were positive for *S. sonnei*. Three other persons from two other households had signs and symptoms suggestive of shigellosis, but all refused cultures.

The third location, Jordan Creek, revealed a single case in a patient living with five other family members, none of whom became ill. The incidence of symptoms is given in Table 1.

All of these areas are located in close proximity to one another, as seen in Figure 3. Residents from separate households within an area frequently visited their neighbors, thus permitting an excellent chance of direct, person-to-person spread. One of the residents from the Blue Creek area had been an overnight guest at the home of one of the Frame Road residents after the outbreak at Blue Creek and just prior to the outbreak at Frame Road, thus possibly providing a route of transmission from one area to the other. No direct connection was found between Jordan Creek and either of the other two areas.

**TABLE 2**

**Number of Cases of Shigella Reported**

| | *Kanawha County* | *West Virginia* | *United States* |
|---|---|---|---|
| 1968 | 0 | 15 | 12,180 |
| 1969 | 0 | 8 | 14,946 |
| 1970 | 0 | 15 | 13,845 |
| 1971 | 0 | 6 | 16,143 |
| 1972 | 0 | 9 | 20,207 |
| 1973 | 0 | 44 | 22,642 |
| 1974 | 0 | 40 | 22,600 |
| 1975 | 1 | 20 | 16,584 |
| 1976 | 0 | 9 | 13,140 |
| 1977 | 7 | 32 | 16,052 |

* California discontinued reporting 1976

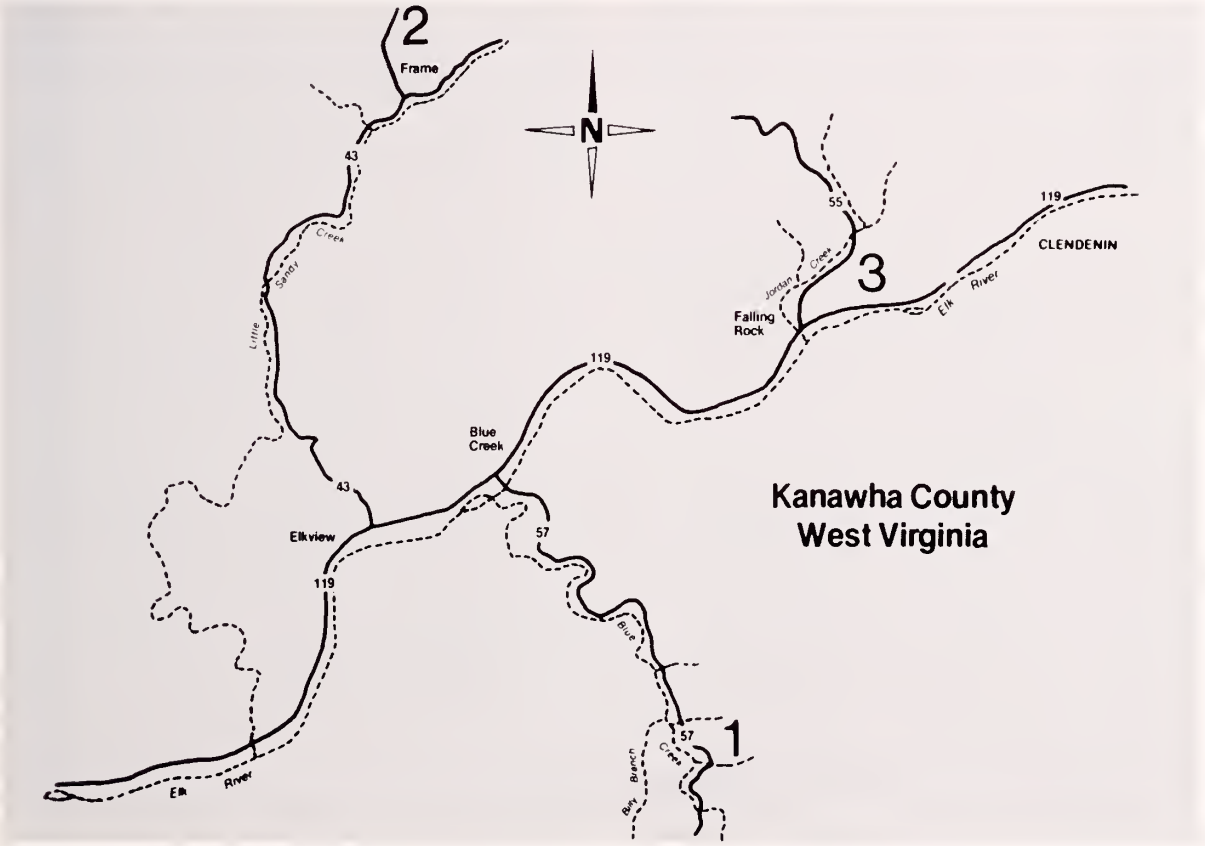


**Figure 3. Overview of Kanawha County showing the three areas yielding cases of shigellosis.**

## Discussion

There were 7.42 cases of shigellosis per 100,000 population reported in 1977 in the United States.[4] During the same year there were only 32 cases reported in West Virginia (1.73 cases per 100,000 population) with seven cases from Kanawha County.[4] During the 10-year interval from 1968 through 1977 there were 198 cases reported in West Virginia and only eight cases from Kanawha County (Table 2).

In 1977, the census report established the population of West Virginia at 1.86 million. If shigellosis is occurring at the national rate, 138 cases should have been reported in West Virginia during 1977. Furthermore, as can be seen from Table 3, the bordering states all exceed West Virginia in reported cases of shigellosis during 1977.

The reported number of cases of shigellosis in Tennessee during 1977 was more than twice the reported incidence in West Virginia. Tennessee has a rural population and sanitation standards which are similar to West Virginia, suggesting that the actual incidence of shigellosis should be nearly identical. The low incidence in West Virginia at both the state and county level may represent under-reporting of diagnosed cases, under-diagnosed cases, or both.

**TABLE 3**

**Incidence of Shigellosis, 1977**

| | |
|---|---|
| West Virginia | 32 |
| Maryland | 416 |
| Ohio | 196 |
| Kentucky | 68 |
| Virginia | 78 |
| Pennsylvania | 244 |
| Tennessee | 166 |
| North Carolina | 82 |

Although shigellosis may present a confusing clinical picture suggestive of appendicitis or pelvic inflammatory disease, the most common clinical presentation of shigellosis is that of a diarrheal syndrome, accompanied by fever, vomiting, anorexia and crampy abdominal pain. The diarrheal stools are watery, colored green to yellow, often tinged with blood and mucus. Tenesmus accompanies the diarrhea.

Shigellosis must be differentiated clinically from salmonellosis, viral enteritis, giardiasis, and amebic dysentery (Table 4). In salmonellosis, nausea and vomiting are more frequent. The patient with salmonella infection may have rigors, which are rare with shigellosis, and the patient usually lacks tenesmus. Patients with both salmonella and shigella have neutrophils in the stool, but may be differentiated by bacterial culture. Viral enteritis and giardiasis are less commonly associated with fever and, when it occurs, the fever is of low grade. Neither blood nor pus is seen in the stools of patients with viral enteritis or giardiasis. Amebic dysentery shows little or no fever and infrequent tenesmus. Amebiasis may be distinguished by proctoscopic examination, which shows undermined ulcers with islands of normal tissue, whereas with shigellosis there is diffuse mucosal involvement.

**TABLE 4**

**Clinical Differential Diagnosis of Shigellosis**

| | *Incubation Period (Usual)* | *Neutrophils in Stool* | *Blood in Stool* | *Vomiting* | *Fever* | *Abdominal Pain* | *Tenesmus* | *Diarrhea* |
|---|---|---|---|---|---|---|---|---|
| Shigella | 36-72 hr | ++++ | + | unusual | usual | + diffuse | + | +++ |
| Salmonella | 8-48 hr | ++ | | common | usual | ++ diffuse | − | + − |
| Amebiasis | 1-6 months | − | | − | − | RLQ | + | |
| Viral Gastro-enteritis | variable | − | − | common | absent (low) (grade) | diffuse | − | |
| Giardiasis | | − | − | − | − | epigastric ++ | − | |
| Appendicitis | − | − | − | + | + | ++ | − | |
| Pelvic Inflammatory Disease | − | − | − | − | ++ | + | − | − |

A stool specimen which has been concentrated and counterstained with iodine should reveal the cysts of amebiasis and giardiasis.

Definitive diagnosis rests upon isolation of the shigella bacillus from the gastrointestinal tract. A rectal swab is preferred over a stool specimen when looking for shigella because the acid produced by overgrowth of normal bacteria flora in a stool specimen will inactivate the shigella.[8] This swab should not be permitted to dry out as shigella are very sensitive to drying. If the specimen cannot be plated within a few hours, the swab should be placed in a buffered glycerol-saline solution for preservation.[9]

Possible sources of our outbreak are water, food, and fecal-hand-oral spread. Waterborne shigellosis has been reported and confirmed.[11,12] Evidence favoring water as the source here includes the facts that all residents with shigellosis lived in close proximity of a stream, all of them had open wells as the sole source of drinking water, and most had outside toilet facilities on the same level as their wells. The cases occurred during and after a time of heavy rain, thus causing saturation of the ground with runoff and possible cross-contamination. Lastly, many of the residents had been swimming in Blue Creek, and shigellosis may be acquired by swimming in contaminated water.[10]

There are two factors against water being the source or vehicle. The involved areas are not downstream from one another (Figure 3). Furthermore, all cultures obtained from the wells and waterways were negative for shigella.

### Varying Dilution Effect

Negative cultures of the water, however, do not rule out water as the source. The varying dilution effect of flowing water makes it difficult to obtain representative specimens for culture and, since it has been shown that challenge with as few as 200 organisms will produce disease in 25 per cent of volunteers, it is quite possible that our sampling was too limited to uncover small numbers of shigella, intermittently contaminating the waterways. Similarly, only one of the many wells was sampled.

The second possible source for our outbreak was food, but this was unlikely as the residents of the three separate locations shared no common food source; however, food may have contributed indirectly.

The most likely vehicle of transmission is fecal-hand-oral. This supposition is supported by the Center for Disease Control reports of 35 epidemics investigated in 25 states during the period of 1964 through 1973 where two thirds of these were found to be transmitted by the fecal-hand-oral route.[2]

### Antibiotics Debated

Antimicrobial treatment of shigellosis has been debated in the literature.[13] Patients with mild disease would appear not to require antibiotics; whereas, in more severe cases antibiotics have been shown to shorten the duration of diarrhea and eliminate shigella from the stool.[14] Ampicillin has been considered the treatment of choice in a dose of 500 mg. four times a day orally for five days in adults, and 12.5 per kg. per six hours orally for five days in children.[5] if the organisms are sensitive.

A study at Southwestern Methodist University reported 176 cases of shigellosis of which 17 per cent of *S. flexneri* (16 of 92) and 45 per cent of *S. sonnei* were resistant to tetracycline, sulfonamides, and choramphenicol.[16] *In vitro* susceptibility tests of 227 strains of shigella were performed, and it was found that all strains were sensitive to the combination of trimethorpim-sulfamethaxozole, although 56 per cent were resistant to sulfamethaxozole by itself.[17]

In England, susceptibility testing of 209 strains of *S. sonnei*, 92 per cent of which were resistant to ampicillin, revealed uniform susceptibility to trimethoprim - sulfamethaxozole.[18] Therefore, it appears that the trimethoprim-sulfamethaxozole combination may be useful for treatment of shigellosis, especially if the sensitivities are known.

Amoxicillin does not appear to be useful in treating shigellosis at a dose of 250 mg. four times daily.[19] Since higher doses have not been studied it is not known whether this treatment failure is due to inadequate dosage.

Successful treatment of shigellosis with a single 2.5-gm. dose of oral tetracycline has been reported.[20] One dose of tetracycline resulted in a clinical response in 100 per cent and a bacteriologic response in 88 per cent of patients with shigella isolates found to be sensitive to tetracycline using broth dilution technique. More significant, however, was the finding that clinical and bacteriologic response was noted in 89 per cent (16 of 18) of patients with tetracycline-resistant organisms treated with 2.5 gm. of oral tetracycline. This initial study suggests that single-dose oral tetracycline therapy may be effective and particularly helpful when sensitivity testing is not available or patient compliance is a problem. Such therapy must be limited to patients over eight years of age because

of dental discoloration by tetracycline in children.[21] It also should be noted that previous studies have shown single-dose ampicillin or cephalexin therapy to be inadequate.[22] Fluid and electrolyte therapy should be given in the dehydrated patient. Opiates should not be used as they may prolong the duration and excretion of shigella.[23]

### Summary

Shigellosis has been shown to exist in West Virginia and should therefore be considered in any patient with an acute diarrheal syndrome and in the differential diagnosis of suspected appendicitis and pelvic inflammatory disease. Proper diagnosis rests upon a high index of clinical suspicion, appropriate specimen collection and adequate laboratory work-up. Contacts of culture-proven cases should be identified and treated to prevent further spread. Ampicillin, trimethoprim-sulfamethaxozole, and tetracycline are all effective therapies for shigellosis. Tetracycline may be the most logical choice as it requires only a one-time dose and eliminates the worry of compliance.

### References

1. Shiga K: Ueber den Erreger der dysenterie in Japan. *Zentraebl Bakteriol Abt* 1, 599, 1898.

2. Rosenberg ML, Weissman JB, Gangarosa EJ, Reller LB, Beasley RP: Shigellosis in the United States: Ten year review of nationwide surveillance, 1964-1973. *Am J Epidemiol* 104:543, 1976.

3. Gangerosa EJ: Shigellosis, in *Communicable and Infectious Diseases,* Top and Wehrle, p 617 1976.

4. Shigella Surveillance, Report Number 39, Annual Summary, Center for Disease Control, 1976.

5. Levine MM, Gangarosa EJ, Werner M *et al.*: Shigellosis in custodial institutions. *J Pediatr* 84:803, 1974.

6. Reller LB, Spector MI: Shigellosis among Indians. *J Infect Dis* 121: 355, 1970.

7. Weissman JB, Schmerler A, Weiler P *et al.*: The role of pre-school children and day care centers in the spread of shigellosis in urban communities. A new high risk group in the USA. *J Pediatr* 84:797, 1974.

8. Finegold SM, Martin WJ, Scott EG: *Diagnostic Microbiology,* ed 5, Bailey and Scott, p 29, 1978.

9. Ewing WH, Martin WJ: Enterobacteriaceae, in Lennette, Spaulding and Truant (eds): *Manual of Clinical Microbiology,* ed 2, Washington, D. C., American Society for Microbiology, p 196, 896, 1974.

10. Rosenberg ML, Hazlett KK, Schaefer J, Wells JG, Pruneda RC: Shigellosis from swimming. *JAMA* 236:1849, 1976.

11. Drachman RH, Payne FJ, Jenkins AA *et al.*: An outbreak of waterborne shigella gastroenteritis. *Am J Hyg* 72:321, 1960.

12. Morbidity and Mortality, 22: Number 47, Center for Disease Control, November 24, 1973.

13. Weissman JB, Gangarosa EJ, DuPont HL, Nelson JD, Haltalin KC: Shigellosis. To treat or not to treat? *JAMA* 229:1215, 1974.

14. Haltalin KC, Kusmiesz HT, Hinton LV, Nelson JD: Treatment of acute diarrhea in outpatients. *Am J Dis Child* 124:554, 1972.

15. Haltalin KC, Nelson JD, Kusmiesz HT, Hinton LV: Optimal dosage of ampicillin for shigellosis. *J Pediatr* 74:626, 1969.

16. Nelson JD, Kusmiesz HT, Jackson LH, Woodman E: Trimethoprim-sulfamethaxozole therapy for shigellosis. *JAMA* 235:1239, 1976.

17. Rudoy RC, Nelson JD, Haltalin KC: In vitro susceptibility of shigella strains to trimethoprim and sulfamethaxozole. *Antimicrob Agents Chemother* 5:439, 1974.

18. Jarvis KH, Scrimgeour G: In vitro sensitivity of *Shigella sonnei* to trimethoprim-sulfamethaxozole in enteric infections. *J Med Microbiol* 3:554, 1970.

19. Nelson JD, Haltalin KC: Amoxicillin less effective than ampicillin against shigella in vitro and in vivo: Relationship of efficacy to activity in serum. *J Infect Dis* 219:5222, 1974.

20. Pickering LK, DuPont HL, Olarte J: Single dose tetracycline therapy for shigellosis in adults. *JAMA* 239:853, 1978.

21. Yaffe SJ, Bierman CW, Cann HM *et al.*: Requiem for tetracyclines. *Pediatrics* 55:142, 1975.

22. DuPont HL, Hornick RB: Clinical approach to infectious diarrheas. *Medicine* 52:265, 1973.

23. DuPont HL, Hornick RB: Adverse effects of Lomotil therapy in shigellosis. *JAMA* 226:1525, 1973.

# Primary Squamous Cell Carcinoma Of The Endometrium: A Case Report

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*Primary squamous cell carcinoma of the endometrium is very rare. Usually, this lesion is associated with squamous cell carcinoma of the cervix.*[1,2,5,9,10] *Fluhmann,*[3] *in 1928, was the first to describe the primary squamous cell carcinoma of the endometrium. Since then only 21 cases have been reported. A case of primary squamous cell carcinoma of the endometrium, what we believe to be the 22nd case, is presented.*

A 78-YEAR-OLD white woman, para 0-0-0-0, was admitted to the hospital for a dilatation and curettage because of serosanguinous vaginal discharge for eight months.

Pelvic examination revealed a normal-appearing cervix with a small uterus and no palpable tumor in the parametrium. The ovaries were not remarkable. On April 10, 1979, the dilatation and curettage was performed. The curettings showed well-differentiated squamous cell carcinoma (Figure 1).

On April 16, 1979, a total abdominal hysterectomy with bilateral salpingo-oophorectomy was done. The patient's postoperative course was complicated by atrial fibrillation on the fourth day, which was treated in the usual fashion. The subsequent course was uneventful and she was discharged on the thirteenth day following surgery. The patient is doing well without any further treatment.

### Pathology

Grossly, the uterus measured 8 x 6 x 5 cm. and weighed 80 grams. The fundus of the uterus revealed one small leiomyoma (1.5 cm. in diameter). The cervical os and canal were patent. The endometrial surface of the fundus and upper part of the body showed a gray-white tumor which exhibited minute papillary configurations on the surface (Figure 2). The ovaries were atrophic and the tubes were unremarkable. Multiple sections were taken from the endometrium with neoplasm and cervix.

On microscopic examination, the squamous cell carcinoma largely replaced the endometrial stoma. Few benign endometrial glands were seen in between the tumor and myometrium (Figure 3). There was no evidence of squamous metaplasia of the endometrium and, except for a few areas of lymphocytic infiltrate near the tumor, the endometrium was free of inflammation. The myometrium was free from tumor. The cervix did not reveal any tumor.

### Discussion

Pure primary squamous cell carcinoma of the endometrium is extremely rare. It fulfills the following three criteria (Fluhmann[3]): (1) no co-existing endometrial adenocarcinoma, (2) no demonstrable connection between this carcinoma and the stratified squamous epithelium of the cervix, and (3) no primary carcinoma in the cervix. Our case falls into the above-men-

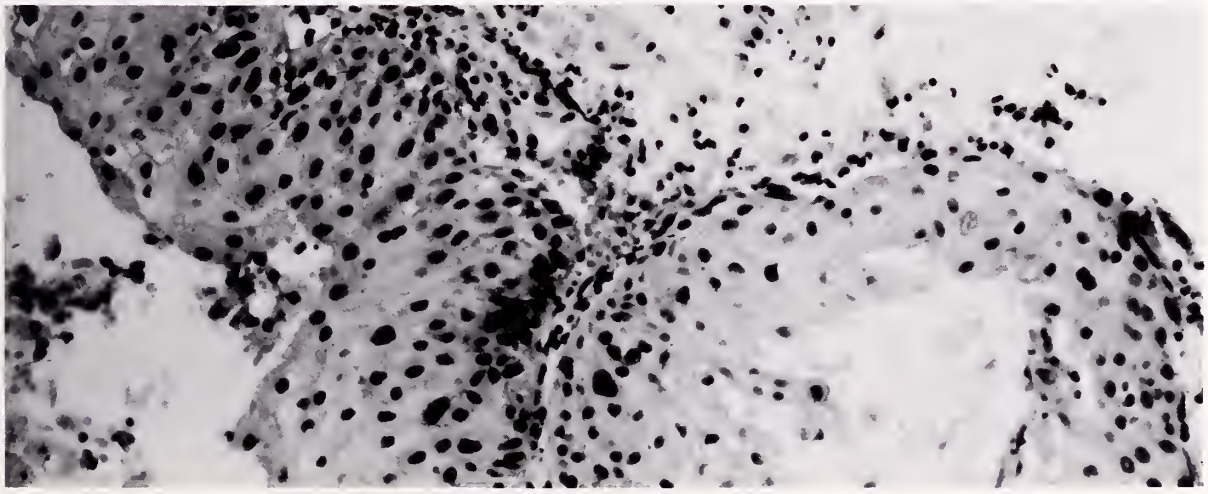

**Figure 1. Endometrial curettings showing nests of squamous cell carcinoma. (H&E. x100)**

tioned category as it fulfills the Fluhmann's criteria.

Primary squamous cell carcinoma of the endometrium may arise through squamous metaplasia of the endometrial surface epithelium, which has been reported in association with various conditions like pyometra, nonspecific and specific endometritis, tuberculosis, syphilis, radiation, vitamin A deficiency, endogenous or exogenous estrogen, chronic inversion, foreign bodies including IUDs, and chemical agents.

Of all the cases reported in the literature, hysterectomy was the primary mode of treatment. Eight cases received combined surgery and radiotherapy. Surgical intervention appears to be the treatment of choice without any evidence of metastasis.

**Figure 2. Opened uterus showing gray-white tumor with papillary configurations in the endometrial surface of fundus and body.**

The prognosis of primary endometrial squamous cell carcinoma is poor compared with the greater than 70 per cent five-year survival with adencarcinoma or adenocanthoma of the endometrium.[8]

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**References**

1. Baggish MS, Woodruff JD: The occurrence of squamous cell epithelium in the endometrium. *Obstet Gynecol Survey* 22:69-115, 1967.

2. Barnett H: Squamous cell carcinoma of the body of the uterus. *J Clin Pathol* 18:715-722, 1965.

3. Fluhmann CF: Squamous epithelium in the endometrium: Benign and malignant condition. *Gynecol Obstet* 46:309-316, 1928.

4. Gillespie CF: Chronic inversion of the uterus with presenting epidermoid carcinoma. Report of a case. *Obstet Gynecol* 20:801, 1962.

5. Kanbour AI, Stock RJ: Squamous cell carcinoma in situ of the endometrium and fallopian tube as superficial extension of invasive cervical carcinoma. *Cancer* 42:570-580, 1978.

6. Malinak LR, Miller GU, Armstrong JT: Primary squamous cell carcinoma of the fallopian tube. *Am J Obstet & Gynecol* 95:1167-1168, 1966.

7. Melin JR, Wanner L, Schulz DM, Cassel EE: Primary squamous cell carcinoma of the endometrium. *Obstet Gynecol* 53:115-119, 1979.

8. Pokoly T: A comparison of the clinical behavior of uterine adenocarcinoma and adenoacanthomas. *Am J Obstet Gynecol* 108:1080, 1970.

9. Qizilbash A, Depedrillo A: Endometrial and tubal involvement by squamous carcinoma of the cervix. *Am J Clin Pathol* 64:668-671, 1975.

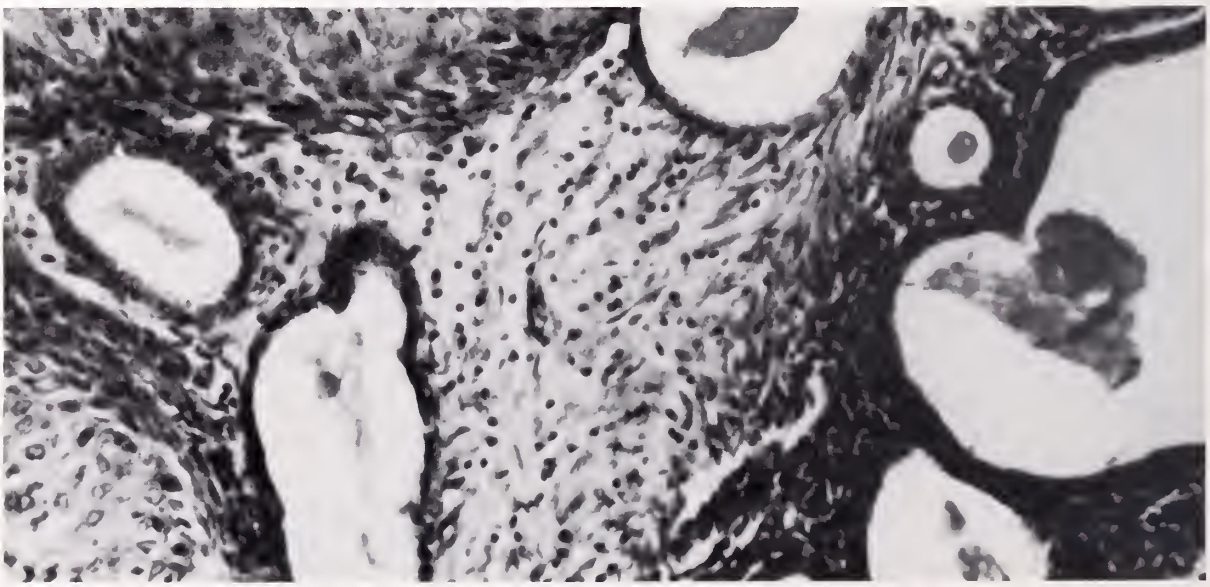

**Figure 3. A section from the surface of the neoplasm showing benign endometrial glands in between squamous cell carcinoma and myometrium. (H&E. x 100)**

# Medical Grand Rounds

**From the West Virginia University Medical Center**

Edited By
*Irma H. Ullrich, M. D.*
*Associate Professor of Medicine*

## A Review Of Lithium

Discussants:
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E. SAMUEL GUY, M. D.
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*Lithium has been used for the treatment of various illnesses throughout medical history. Only recently has it been proven clinically to be effective in the treatment and prophylaxis of bipolar affective disorder (manic-depressive illness). There have been numerous side effects associated with lithium therapy most commonly involving the gastrointestinal, renal and central nervous system. Because of a low therapeutic index, lithium administration requires careful monitoring of serum levels. Many promising theories describing its mechanism of action have evolved but none has yet proven conclusive.*

THERE are references to the treatment of mania as early as the work of Soranus, a Roman physician, who said, "In the treatment of mania, use should be made of natural waters, such as alkaline springs." Lithium (lithium carbonate—Eskalith) was first identified in 1817 by Arfvedson. His professor, Baron Berzelius, named the oxide *lithion* because it was found in rocks. The next major references to lithium came from the work of Garrod in 1859 as he searched for the cure for gout. In 1927, Culbreth wrote of its use as a sedative hypnotic. Somewhat later Squires attempted to popularize its use in epilepsy: however, the dose required caused lithium toxicity.

In 1949, parallel events took place on two continents that shaped the future of lithium in medicine. In Australia, John Cade successfully treated a series of 10 patients with mania. In the United States, Corcoran *et al.* reported two cases of fatal lithium toxicity secondary to its unrestricted use as a salt substitute. This resulted in the withdrawal of lithium from the United States market. Thus, while research and clinical use of lithium continued in other countries, it was not until 1960 that lithium was approved for experimental use in this country. In 1970, it was approved for the treatment of acute mania and, in 1974, for the prophylaxis of recurrent manic attacks.

### Absorption and Excretion

Gastrointestinal absorption approaches 100 per cent in eight hours. The peak serum level occurs in one to three hours. Lithium is not protein bound. It is initially distributed in the extracellular fluid, then accumulated in various tissues. Cerebro-spinal fluid, red blood cell, and breast milk levels are approximately 50 per cent of that of serum, while certain other organs, thyroid and pituitary, for example, have been shown to have concentrations four times that of serum. The final volume of distribution approximates total body water.

Approximately 95 per cent of lithium carbonate is eliminated via the kidneys. Lithium clearance is about 20 per cent of the glomerular filtration rate. Seventy to 80 per cent is reabsorbed in the proximal renal tubules. Although sodium is further absorbed distally, lithium is not, and its excretion is therefore not facilitated by diuretics that act at the distal tubules. Moreover, because the proximal reabsorption of these two

ions is competitive, a deficiency of sodium tends to increase the retention of lithium. Therefore, extra precaution needs to be taken when the use of diuretics, salt restriction, dehydration, or sodium wasting occurs in order to avoid lithium toxicity. Chronic administration of lithium will result in the level gradually increasing during the first five to six days until equilibrium between ingestion and excretion occurs. If lithium therapy is stopped, a rapid elimination phase is seen in the first six hours, and then tapers off so that one half of the total lithium load is excreted in 24 hours and the remainder is eliminated in 10 to 14 days.

### Administration

Lithium carbonate is marketed in 300 mg. tablets and capsules. The average maintenance dose is 900 mg. per day, but can vary from 150 mg. to two grams daily. Baseline laboratory studies prior to initiating lithium treatment should include: serum electrolytes, thyroxine, creatinine, and ECG. In spite of lithium's relatively long half-life of 24 hours, multiple-dosage scheduling is usually required because of gastric side effects. By convention, lithium levels are obtained 12 hours after the previous dose. The therapeutic range of lithium is usually quoted as being between 0.6 to 1.4 mEq/1. The lower ranges are used for chronic maintenance. In outpatient maintenance therapy, lithium levels should be obtained at one to two-month intervals. Lithium has a very low therapeutic index in that signs of mild toxicity are usually present with levels greater than 1.5 mEq/1. Moderate to severe toxicity occurs with levels greater than 2 mEq/1.

### Use in Mania

Even though many of the initial studies of the treatment of mania were uncontrolled or single blind, virtually all of them suggest that lithium is effective. Several subsequent double blind, placebo-controlled studies show that it is effective in over 70 per cent of patients (Table 1). In a group of studies summarized by Goodwin and Zis (1979), the use of neuroleptics was compared to lithium. They noted that a phenothiazine (Thorazine) or buterophenone (Haldol) was superior to lithium in its "calming" effect and its more rapid onset of action. Lithium, on the other hand, was of more value in ameliorating the symptoms most specific to the manic syndrome. For these reasons, the manic patient initially may be placed on a neuroleptic or a combination of a neuroleptic plus lithium. The dose of the neuroleptic is then reduced as the lithium becomes therapeutically effective.

Davis (1976) reviewed the evidence for a prophylactic effect of lithium in manic illness. In eight studies utilizing random patient assignment, placebo-control, and blind evaluations, the overall results were strongly supportive that lithium was more effective in preventing the recurrence of mania than placebo. He noted that an average of 36 per cent of lithium-treated patients relapsed as compared with 79 per cent of patients who received placebo.

**TABLE 1**

**Lithium in Treatment of Mania**

| *Studies* | *Dates* | *No. of Studies* | *No. of Patients* | *% Response to Lithium* |
|---|---|---|---|---|
| Open and Single Blind | 1949-1970 | 10 | 403 | 81 |
| Double Blind Lithium vs. Placebo | 1954 1971 | 4 | 106 | 76 |
| Double Blind Lithium vs. Neuroleptics | 1968-1975 | 8 | 228 | >70 (in 7 of 8 studies) |

### Lithium in Depression

Although John Cade made no mention of lithium's effect on depression in 1949, several workers since then have investigated this aspect. Mendel's (1979) work provides an excellent review of the world's literature, showing eight of 11 controlled studies in which lithium was found to have a statistically-significant antidepressant effect. Another observation was that acute antidepressant responses were more frequent in bipolar in comparison to unipolar patients in four out of five studies.

In four out of four studies (three of which were double blind, placebo-controlled), lithium was strongly suggested to be effective in preventing the recurrence of depression (Table 2). Further prospective studies are needed, howev-

**TABLE 2**

**Lithium Prophylaxis of Unipolar Affective Illness**

| *Study* | *Date* | *Type* | *No. of Patients on Lithium* | *Results* |
|---|---|---|---|---|
| Persson | 1972 | Historically controlled | 21 | Lithium > Untreated |
| Baastrup | 1970 | Double blind Placebo-controlled | 17 | Lithium ≫ Placebo |
| Copper | 1971 | Double blind Placebo-controlled | 11 | Lithium ≫ Placebo |
| Prier | 1973 | Double blind Placebo-controlled | | Lithium = Imipramine Lithium > Placebo |

er, primarily because of the small number of patients studied to date as well as the inexactness of the definition of unipolar illness.

### Other Psychiatric Uses

Because of lithium's well-documented therapeutic effect in bipolar affective disorder, various workers have tried it in other psychiatric disorders. Sheard *et al.* (1976), for example, documented decreased aggressive behavior in male prisoners convicted of serious, aggressive crimes. Merry *et al.* (1976) noted its beneficial effect in reducing ethanol abuse in depressed alcoholics. Lithium's benefit is less well documented in the treatment of the emotionally-unstable character disorder, the schizoaffective disorder, and childhood behavior disorders. It is quite possible that the lithium responders in each instance noted above represent a subset of manic-depressive illness.

### Medical Uses

There are numerous articles concerning possible medical uses of lithium. Most of these are the result of an effect upon a secondary disease process while patients are being treated with lithium for manic-depressive illness. Lithium has been used in thyrotoxicosis and found to be of benefit in decreasing serum thyroxine levels. There is evidence for several sites of action of lithium in thyroid metabolism, but its major effect is that it inhibits thyroid hormone release. Iodine is preferred to lithium because of fewer side effects. Lithium has been used with beneficial results in treating the syndrome of inappropriate antidiuretic hormone release. However, the disadvantages of lithium therapy seem to outweigh the advantages, and demeclocycline (Declomycin) has been shown to be superior. Granulocytopenic states, specifically Felty's syndrome, aplastic anemia, and chemotherapy-induced granulocytopenia, have been treated with lithium. It may increase peripheral white counts by stimulating bone marrow activity.

### Drug Interactions

The major drug interactions of lithium are with diuretics, neuroleptics, antidepressants, and iodides. Thiazide diuretics have been studied extensively and it has been shown that they decrease lithium clearance and, thereby, increase lithium levels from 25 to 100 per cent. Thiazides induce sodium depletion, thereby increasing the proximal tubular absorption of lithium. Other diuretics have been less well studied. Cohen and Cohen, in 1974, reported four cases of an acute encephalopathy that took place shortly after lithium and haloperidol (Haldol) were administered concurrently. Two of these patients had severe, irreversible brain damage. These patients were all seen in the same hospital over a five-month period. This report has not been verified by other investigators. The prevailing medical opinion is that haloperidol and lithium used concomitantly are safe and effective for the treatment of mania.

There are no adverse interactions with tricyclic antidepressants or MAO inhibitors. There are reports that the combination of lithium and an MAO inhibitor or a tricyclic antidepressant may be effective in treating an otherwise refractory depression. Also, there is a "manic overshoot" phenomenon which sometimes occurs when treating bipolar patients in their depressed phase with anti-depressants alone. Concurrent lithium therapy may protect against this. Lithium and iodides used concurrently may induce hypothyroidism.

### Side Effects

There have been numerous side effects associated with lithium therapy. Central nervous system and neuromuscular side effects can be grouped into mild, moderate, and severe, and generally correlate with increasing lithium levels.

Mild symptoms include: fatigue, lethargy, muscle weakness, dizziness, tremor, and blurred vision.

Moderate symptoms include: muscular irritability with twitching, increased deep tendon reflexes, extra-pyramidal effects (including cogwheel rigidity), ataxia, coarse tremor, dysarthria, incoordination, difficulty concentrating, apathy, disorientation and confusion.

Severe symptoms include: coma, severe muscle irritability, a generalized peripheral neuropathy, delirium, auditory and visual hallucinations, and death.

Mild and moderate symptoms are seen commonly with therapeutic drug levels, but seizures and a myasthenia gravis-like syndrome have also been observed with therapeutic levels. CNS side effects may be more closely related to erythrocyte lithium levels than to serum levels.

Polyuria and polydipsia were noted in over 50 per cent of all patients starting lithium therapy and were still present in 25 per cent after one to two years (Schou, 1970). With chronic use renal structural lesions have been observed on biopsy, including an increased number of sclerotic glomeruli, tubular atrophy, and interstitial fibrosis. Benign, reversible T-wave changes

are the most common lithium-induced ECG changes. Schou (1968) noted T-wave flattening or inversion in 20 per cent of lithium-treated patients. Lithium may be used safely in cardiac patients with clear psychiatric indications as long as lithium levels, electrolytes, and ECG changes are monitored.

### Gastrointestinal Effects

Approximately one third of patients starting lithium therapy will experience gastrointestinal side effects (Schou, 1970), but these usually abate with continued therapy. The severity of the symptoms correlates with the steepness of the rise in serum lithium following oral ingestion. Chronic lithium therapy is associated with a four-per-cent incidence of goiter (Schou, 1968). The majority of these patients are clinically euthyroid and have a normal serum thyroxine. Lithium has complex effects on carbohydrate metabolism, both hormonally and cellularly. Animal studies show that lithium affects at least five separate stages of carbohydrate metabolism. Clinical studies have shown both an increase and a decrease in glucose tolerance. It seems that single-dose or short-term lithium use decreases glucose tolerance, and long-term use increases glucose tolerance. The predominant effect in these long-term patients appears to be an insulin-like effect to increase glucose tissue uptake and increase liver glycogen synthesis. Patients on long-term lithium treatment have been noted to have increased parathyroid hormone levels and increased serum calcium and magnesium levels compared to control groups.

The most notable dermatologic manifestation is a maculo-papular rash which appears during the first week of lithium administration that resolves with discontinuing lithium.

Finally, animal studies show that lithium exposure early in development has a teratogenic effect. There also appears to be a somewhat higher risk of cardiovascular malformation with maternal lithium intake in humans. Lithium crosses the placental membrane freely so that at delivery the child's lithium level is equal to the mother's. Therefore, its use in pregnancy is indicated in only the most severe cases of otherwise uncontrollable mania.

### Mechanisms of Action

Why lithium is an effective treatment for bipolar affective illness is not known. There have been numerous studies directed at elucidating the mechanism of action, and while a number of promising theories have evolved, none has proven conclusive. Size, charge, electrical field density, and energy of hydration are properties of lithium which are thought to play a major role.

Bunney *et al.* (1979) have postulated that the ionic concentration gradient across the cell membrane alters protein carrier specificity for norepinephrine in a way that norepinephrine reuptake into the presynaptic cell is facilitated. They have also suggested that mania may be secondary to a functional rather than absolute increase in catecholamine activity. This could be explained by the release of a neurotransmitter that is amplified by a supersensitive neuronal receptor. In a number of systems, kidney, thyroid, and CNS, it has been shown that lithium interacts with cyclic AMP-mediated processes (Singer and Rotenberg, 1973).

There have been several studies comparing intracellular to extracellular lithium and sodium ratios as a possible predictor of lithium responsiveness, but these electrolyte ratios are not clinically applicable at this time. The best predictor of lithium response is how closely the patient fits the stereotype of bipolar illness, displaying an episodic, grandiose, cyclothymic, retarded-depressive, hereditary presentation.

Lithium is the cornerstone of modern treatment of manic-depressive illness. Lithium has also been very important to psychiatry because it has made physicians acutely aware of the need for better diagnostic methodologies and systems; no longer is every psychotic patient a schizophrenic. Its low therapeutic index makes careful surveillance of patients essential.

### Selected References


Baldessarini RJ, Lipinski JF: Lithium salts: 1970-1975. *Ann Intern Med* 83:527-533, 1975.

Bunney WE Jr, Pert A, Rosenblatt J, Pert C, Gallaper D: Mode of action of lithium. *Arch Gen Psych* 36:898-901, 1979.

Cade J: Lithium salts in the treatment of manic excitement. *Med J of Australia* Sept 3, 1949, pp 349-352.

Cohen W, Cohen N: Lithium carbonate, haloperidol, and irreversible brain damage. *JAMA* 230:1283-1287, 1974.

Davis JM: Overview: Maintenance therapy in psychiatry: II. Affective disorders. *Am J Psychiatry* 133:1-13, 1976.

Goodwin FK, Zis AP: Lithium in the treatment of mania. *Arch Gen Psych* 36:840-844, 1979.

Jefferson JW, Greist JH: *Primer of Lithium Therapy*. Baltimore, Williams and Wilkins Co, 1977.

Mendels J: Lithium as an antidepressant. *Arch Gen Psych* 36:845-846, 1979.

Merry J, Reynolds C, Bailey J, Coppen A: Prophylactic treatment of alcoholism by lithium carbonate. *Lancet* Sept 4, 1976 pp 481-482.

Schou M: Lithium in psychiatric therapy and prophylaxis. *J Psychiat Res* 6:67-95, 1968.

Schou M: Lithium as a prophylactic agent in unipolar affective illness. *Arch Gen Psych* 36:849-851, 1979.

Schou M: Lithium in the treatment of other psychiatric and nonpsychiatric disorders. *Arch Gen Psych* 36:856-859, 1979.

Schou M, Baastrup PC, Grof P *et al.*: Pharmacological and clinical problems of lithium prophylaxis. *Brit J Psychiatry* 116:615-619, 1970.

Sheard MH: Lithium in the treatment of aggression. *J Neur Ment Dis* 160:108-118, 1975.

Singer I, Rotenberg D: Mechanisms of lithium action. *N Engl J Med* 289:254-260, 1973.

# Surgical Treatment of Ulcers Curtailed

What's new in ulcers?

Much, from the viewpoint of the sufferer. Most ulcers can now be treated with medications, and there seldom is need for surgery today.

We are living in a new ulcer-treatment era, according to a survey report in a recent issue of an American Medical Association specialty journal, Archives of Surgery.

New medications have made it possible to treat most ulcers with drugs, and it seldom is necessary to resort to surgery to cope with the painful internal ailment, said Israel Penn, M. D., of Denver.

A recent research study planned in 14 Veterans Administration hospitals to determine the effectiveness of a certain surgical treatment of duodenal ulcers had to be cancelled, Doctor Penn observed. There weren't enough surgery patients to make a valid study.

Surgeons are enlisted today only for individuals with severe complications that fail to respond to drug treatment.

Along with new treatment methods that make surgery unnecessary there has been a marked decline in the total number of ulcers among Americans and Britons. There is only speculation as to the cause of this decline.

*A message from . . .*

*The President*

## POLITICAL CHOICE

Most doctors I talk to would as soon vote for an orangutan as Jimmy Carter. The trouble is, most doctors feel less than enthusiastic about orangutans and have a certain reservation about the other alternative likely to be offered them.

Mr. Carter is simply seen as a national embarrassment. Most feel toward him like they do about a third grader in the school play who has forgotten his lines—the poor dear! . . . a cute kid but not very bright . . . wonder why his parents allowed him to get into this situation?

I have yet to meet a doctor, however, who would premise his presidential vote on any medical issues. The issues that seem important in their eyes are those general ones apparently important to everyone else—international affairs, inflation, energy, and presidential indecision and incompetence.

Looking back over the past 20 or 30 years, it seems to have made little difference to Medicine whose administration was in office. We've battled with all of them. It has been politically popular and productive of media coverage to kick doctors around, or at least to appear as though you would like to do that if you happened to hold office.

We have acquired a few scars and perhaps some gluteal calluses, but the system we have defended is basically intact and, having survived, seems to be strengthened as a result of its difficult trial.

The real battleground for Medicine has been in the United States Congress. Here is where the decisions are made which affect our professional interests. In the Congressional trenches the Administration can act only as an influence. While not so formidable, we have the same opportunity to be influential in what transpires in Congress.

West Virginia this year has two wide-open Congressional districts to be filled. We have a vital interest in these. Our task of defending the best and most efficient medical care system the world has ever known is not over. It never will be. We are fair game for an assortment of collectivists and social planners because medical care is an important cog in that grand social machine they dream about creating. To many politicians, we are an overflowing cookie jar to be raided, the contents to be exchanged for votes.

It is clear that doctors will be influenced in their choice for President by the very same nonmedical issues which affect and influence any other voter. For their professional concerns, doctors should be actively involved in the election campaigns of those Congressional candidates who will best represent their interests.

Stephen D. Ward, M.D.

Stephen D. Ward, M. D., *President*

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

It's only a little bit of money—$50,000 in a 1980-81 state budget of more than $1 billion—but it could be some of the most productive funding the recent Legislature provided.

**SOME EARLY STEPS IN A BIG EFFORT**

For the second straight year, a steering committee spawned by the State Medical Association will have these dollars with which to work in encouraging community hospitals to develop new medical rehabilitation facilities.

Many of you will remember the background. The Medical Association's Medical Economics Subcommittee on Vocational Rehabilitation obtained 1977 House of Delegates approval for a major new study. The House concurred that a need for medical rehabilitation facilities beyond those available to a limited few at the state's Vocational Rehabilitation Center should be documented.

That was effectively done by the West Virginia University Department of Community Medicine, in conjunction with the Medical Association Subcommittee, in 1978. The 1979 Legislature, with the particular involvement of Senate President W. T. Brotherton, Jr., provided the first $50,000 through the State Health Department account to get some community hospital planning under way.

Six hospitals subsequently presented planning proposals in support of requests for financial assistance from that initial appropriation. At this writing, the Steering Committee representing primarily the state's medical and hospital associations and several governmental components, is moving toward approval of the initial planning grants.

Significantly, the Committee has faced a difficult task. Hospitals in several communities, including Wheeling, Morgantown, Parkersburg, Charleston and Huntington, came up with beautifully documented proposals. That material supported in striking fashion what the WVU-Medical Association study showed — there's a critical need for facilities and other medical rehabilitation resources to provide appropriate rehabilitation care for thousands of stroke and other victims for whom such care simply does not now exist.

This new program admittedly will crawl before it walks. The Steering Committee, facing budget and other realities, knew it could not now justify—nor hope for—legislative support for a multi-million dollar state facility. But there's every reason to envision specialized new units, with perhaps 15 to 25 or so beds each, developed at community hospitals in close coordination with already existing acute care and broad medical staff capabilities.

Senator Brotherton; the Legislature; the West Virginia Health Systems and State Health Planning and Development agencies, and the Rockefeller Administration support this concept.

The challenge now is to get the job done—again recognizing that it requires patient, logical, step-by-step planning, as well as time.

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Time ran out, as the Legislature reached its midnight adjournment deadline on March 8, on a Senate-passed bill proposing a giant step in sports medicine in West Virginia.

**THE TRAINERS' BILL**

Virtually certain to be reintroduced very early next year, the bill would require each county board of education to employ, by January 1, 1985, at least one licensed athletic trainer in each senior high school in its county.

The "legislative findings and declarations of policy" section of the bill sets the background for it. Under that section, the Legislature would find it necessary "to protect certain athletes of this state from the unauthorized, unqualified and unregulated practice of athletic training."

The section then offers this specific purpose for the legislation: "to require all individuals who are engaged in the practice of athletic training (as defined in the bill) to be licensed by the

State Board of Education to practice such profession, and to require all senior high schools in this state, by January 1, 1985, or at a later date with the approval of the State Board of Education, to employ an athletic trainer licensed under the provisions of this article and to require such trainer to attend all football games and practices of such educational institution."

From a practical standpoint, it probably was just as well that the 29-page bill was not rushed through to final passage this year. Some extensive reworking of it was necessary in the Senate, and it was passed there with some honest and sincere questions as to implementation of it from cost and other standpoints. There still is a need for some language clean-up, and another look at some provisions for an advisory board to the Board of Education.

Some might also ask if the bill is broad enough, in the light of injury problems in sports other than football, to meet those needs for trainer coverage. There is some language which touches on coverage of other sports activity—presumably including that involving women—but more work on the bill would appear essential in this area.

Meanwhile, the State Board of Education, with Dr. Carl J. Roncaglione, a Charleston orthopedic surgeon and member, spearheading the effort, has a commitment from State Department of Education officials to look in detail into the trainer question. And the Medical Aspects of Sports Committee of the West Virginia State Medical Association listed the bill as an agenda item for a May 3 meeting in Morgantown.

Medical Association involvement in issues like this is not new. The late Dr. Richard Corbitt of Parkersburg really is the father, for example, of the no-pads preliminary conditioning drills which now are a required part of fall football practice at high schools. It was the Medical Aspects of Sports Committee, now headed by Dr. K. Douglas Bowers, Jr., of Morgantown, which provided state high schools in 1977 with specific steps for prevention of heat illnesses—and what actually should be included in a pre-participation physical examination for scholastic football players.

That material was made available to all physician members of the State Medical Association through publication of it in the August, 1977, issue of *The West Virginia Medical Journal*. It also was distributed to high school principals, athletic directors, coaches and others by the West Virginia Secondary School Activities Commission.

Tragically, pre-season football drills last year brought two heat-related deaths at large high schools. Those fatalities generated additional support for the athletic trainers' bill sponsored by Democratic Senators Bob Rogers of Boone County, Richard Benson of Randolph and Robert Nelson of Cabell, although Senator Rogers, in particular, needed no such unfortunate incidents to whet his interest in such legislation.

The Medical Association has a stake in the high school athlete, just as it does in medical rehabilitation matters (please see the preceding editorial). Its Constitution charges it with, among other things, promotion of the public health. Doctor Bowers and his Committee thus have a responsibility for further review of the trainers' bill, and for recommending a logical, effective approach to all medical aspects of sports to the Association Council and House of Delegates.

## Our Readers Speak

### Praises President's Message

(*Addressed to Dr. Stephen D. Ward, Wheeling, President, West Virginia State Medical Association.*)

I read with interest your message on "The Hard Sell" [February issue of *The Journal*]. This is saying it the way it is about as well as I have ever heard it said and I only hope that I could do as well when trying to express myself on the facts as you have put them.

I think that this message should be run as a full page ad in all of the newspapers in the United States (which it can't), and then maybe some of the people will get the idea of what is really going on with some of these useless, expensive programs.

Again, my congratulations on this message.

John L. Fullmer, M. D.
200 Wedgewood Drive, Suite 202
Morgantown 26505

### Lauds 'Human Factor' Article

(*Addressed to Charles R. Lewis, Managing Editor*)

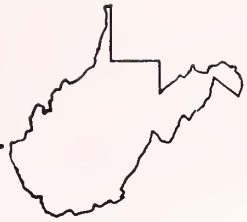
I want to congratulate you on publishing Dr. Charles Hoffman's article, "The Human Factor," in the last [March] *Journal*. I also want to thank Doctor Hoffman for writing it and will appreciate it if you will get the message to him.

After 51 years of General Practice, I am well aware of the value of the human factor. It was always uppermost in my mind in the care of my patients. In fact, I could not accept a patient on any other basis than that of a friend.

I wish every medical student could have a copy of this and have it discussed in classrooms. I agree with every word in the article, and cherish my memory of working with Doctor "Carl" on the Council.

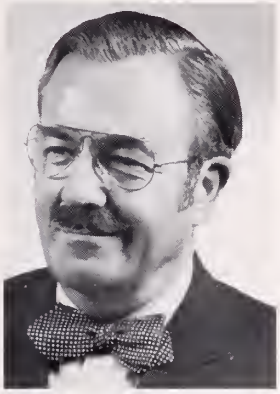
Daniel N. Barber, M. D.
5430 Virginia Avenue
Charleston 25304

# GENERAL NEWS



## Chronically Mentally Ill Convention Subject

Two psychiatrists from Oregon and Illinois will discuss the chronically mentally ill during the 113th Annual Meeting of the State Medical Association August 20-23 at the Greenbrier in White Sulphur Springs.



Rogers J. Smith, M. D.

Patrick R. Staunton, M. D.

Drs. Rogers J. Smith of Portland, Oregon, and Patrick R. Staunton of Park Ridge, Illinois, will speak during the second general session Friday morning, August 22, it was announced by the Program Committee.

Doctor Smith, Chairman of the American Medical Association Council on Scientific Affairs, will speak on "The Primary Physician's Role in Care of the Chronically Mentally Ill."

Doctor Staunton's topic will be "Meeting the Needs of the Chronically Mentally Ill at the Community Level." He is Chairman of the Division of Psychiatry at Lutheran General Hospital in Park Ridge.

Convention activities will get under way with a 2 P. M. meeting of the Association's Executive Committee on Tuesday, August 19; the usual pre-convention meeting of the Council at 9:30 A. M. on Wednesday, and the first session of the House of Delegates at 3 o'clock that afternoon.

Dr. Robert B. Hunter, AMA President Elect, as announced previously, will address the opening House session Wednesday. He will be installed as AMA President in July.

In Portland, Doctor Smith is part-time Chief of the Psychiatric Clinic and is in part-time practice. He also is a member of the staff of the University of Oregon Health Sciences Center Hospitals in Portland, and serves as a Consultant for Blue Cross of Oregon and the Oregon Board of Medical Examiners.

A member of the clinical faculty of the University of Oregon Medical School since 1950, Doctor Smith presently is Associate Clinical Professor, Department of Psychiatry. He was Consultant in Psychiatry at Portland State University from 1957 to 1962.

A native of Richmond, Indiana, Doctor Smith was graduated from Swarthmore (Pennsylvania) College and received his M. D. degree in 1945 from the University of Michigan. He interned at City Hospital in Indianapolis, Indiana, and took his residency at the Menninger Foundation and Winter Veterans Administration Hospital in Topeka, Kansas.

### Delegate to AMA

Certified by the American Board of Psychiatry and Neurology, Doctor Smith is an American Psychiatric Association Delegate to, and Past Chairman of, the AMA Scientific Section of Psychiatry. He also is a member of the Board of Trustees of the Oregon Medical Association; a Life Fellow of the American Psychiatric Association; a charter member and Past President of the Oregon Psychiatric Association; and a Fellow of the American College of Psychiatrists and the North Pacific Society of Neurology and Psychiatry.

Doctor Staunton, who was named to his present post at Lutheran General Hospital in 1979, currently is President of the Illinois Psychiatric Society.

In Chicago, he formerly was Chief, Loyola Service, Illinois State Psychiatric Institute (1959-69); Region Administrator, Illinois Department of Mental Health (1969-73); and Deputy Director for Clinical Services, Illinois Department of Mental Health (1973-75).

Doctor Staunton, who was board-certified in 1959, is a Clinical Associate Professor of Psychi-

atry at the Abraham Lincoln School of Medicine. University of Illinois, and formerly was Clinical Professor of Psychiatry at Loyola University School of Medicine. He was a member of the faculty senate at the University of Illinois Medical Center in 1977-78.

### Ireland Native

A native of Swinford, Ireland, Doctor Staunton received his medical degree in 1952 from the University College Dublin of National University of Ireland. He interned at Mercy Hospital in Chicago and completed residencies in psychiatry and neurology at that hospital and at Cook County Hospital, Chicago, and Chicago State Hospital.

Doctor Staunton is a Fellow of the American Psychiatric Association, and was Chairman of the Council of Mental Health of the Illinois State Medical Association from 1975 to 1978.

Delivering the keynote Thomas L. Harris Address during 9 A. M. opening exercises on Thursday, as announced previously, will be Dr. William R. Barclay, Editor of The Journal of the American Medical Association (JAMA). The first general session will be held immediately following the opening exercises.

Two of the speakers for the first general session, also as announced previously, will be dermatologists from the University of Maryland School of Medicine. They are Drs. Harry M. Robinson, Jr., Professor and former head of the Division of Dermatology, and Joseph W. Burnett, Professor and currently Head of Dermatology.

Doctor Robinson will speak on "Advances in Photochemotherapy," while Doctor Burnett's topic will be "Diagnostic Dermatologic Methods."

### Foods and Medications

In addition to the above presentations, there will be a paper on foods and medications during the first general session.

For the second general session Friday morning, in addition to the presentations by Doctors Smith and Staunton, there will be a paper on children's learning disorders and, during the third and final general session Saturday morning, talks on AMA services and the activities of the AMA's Washington, D. C., office.

The general convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 22).

Plans also call for the usual President's Reception on Wednesday evening, August 20, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P. M. on Saturday. At that House session, Dr. L. Walter Fix of Martinsburg will be inaugurated as President to succeed Dr. Stephen D. Ward of Wheeling.

### Auxiliary to Meet

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. D. Sheffer Clark of Huntington in charge as the Auxiliary's President, again will run concurrently with the Association's convention.

More specific information relative to other general session topics and speakers will be provided in upcoming issues of *The Journal.*

Members of the Program Committee are Dr. M. D. Reiter of Wheeling, Chairman; Doctor Fix, and Drs. David K. Heydinger of Marshall University's School of Medicine in Huntington; Joseph B. Reed, Buckhannon; Stanley Roy Shane of the West Virginia School of Medicine faculty in Morgantown, and John F. I. Zeedick of South Charleston.

## *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*Handbook of Poisoning: Prevention, Diagnosis and Treatment, 10th Edition*, by Robert H. Dreisbach, M. D., Ph.D. 578 pages. Price $9. Lange Medical Publications, Los Altos, California 94022. 1980.

*General Ophthalmology*, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 410 pages. Price $15. Lange Medical Publications, Los Altos, California 94022. 1980.

*Current Pediatric Diagnosis and Treatment, 6th Edition*, by C. Henry Kempe, M. D.; Henry K. Silver, M. D.; and Donough O'Brien, M. D. 1122 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1980.

# Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb. Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meeting are listed in the *Medical Meetings* Department of The Journal).

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

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|---|---|---|
| May 8-9 | Morgantown | Health Officers Seminar |
| May 10 | Charleston | Headache: A Multidiscipline Conference |
| June 7 | Morgantown | Anesthesia Update '80 |
| June 7 | Charleston | 7th Annual Surgery Conference |
| June 13-14 | Charleston | Cytology/Pathology Regional Workshop |
| July 12 | Charleston | CAMC Oncology Symposium: Update on the Management of Melanoma |

## Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

*Cabin Creek* (2nd Wed., 8-10 A. M.)

May 14

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|---|---|
| Common Adolescent Health Problems | Barbara Tenney, M. D. |

*Welch, Stevens Clinic Hospital* (3rd Wed., 11 A. M.-1 P. M.)

May 21

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| Management of Shock | James Boland, M. D. |

June 18

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|---|---|
| Pulmonary Medicine: COPD Treatment | Dominic Gaziano, M. D. |

July 19

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| Common Gynecological Disorders | Narinder Sehgal, M. D. |

*Whitesville* (4th Wed., 11 A. M.-1 P. M.)

May 28

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| Interpersonal Relationships between Health Professionals and Patients | Marshall Carper, M. D. |

June 25

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| Electrocardiogram and the Outpatient Management of Arrhythmias | Maria Georgieve, M. D. |

*Buckhannon, St. Joseph's Hospital* (4:30-6:30 P. M.)

May 22

| | |
|---|---|
| Otitis Media | Edwin Anderson, M. D. |

## Visiting Professors

(Morgantown)

May 16 *Dept. of Radiology*: David H. Baker, M. D., Professor and Director, Pediatric Radiology, The Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City.

May 29-30 *Dept. of Obstetrics and Gynecology*: "The Obstetrician's Unique Challenge—Conflicting Risks of Two Patients" and "Premature Rupture of the Membranes," Watson A. Bowes, M. D., University of Colorado, Denver.

*Dept. of Anesthesia*: One Thursday each month, 4 p. m.

*Dept. of Medicine*: Variable—incorporated in Grand Rounds

*Dept. of Family Practice*: Variable—incorporated in Grand Rounds

## Peer Review Statute Caps Six Years of Effort

Enactment by the 1980 Legislature of Enrolled Committee Substitute for House Bill No. 1207, popularly called the "peer review bill," meant success for the state's medical and hospital associations, in particular, after some six years of effort.

The act, to become effective early in June, considerably expands limitations on evidentiary discoverability and admissibility of peer review proceedings and records in court proceedings. It also broadens legal protection afforded peer review and similar committees: their members, and persons providing information to such committees.

Prior law, enacted in 1975 primarily as a result of efforts by the West Virginia Medical Institute, Inc., leadership, provided such protection only to committee members and employes, as well as persons providing information, from defamation (i.e., libel or slander) suits—provided that the information offered and actions by the committees were related to activities of the review organization; were made in good faith, and were not motivated by malice.

A part of the legislation first introduced in 1975 also sought protection for peer review committee records and proceedings—but it was not until this year, following particularly intensive new efforts begun last summer, that the so-called second half of the measure was passed finally and signed by the Governor.

The new law, while making some semantic changes, keeps in place the 1975 protections—but goes on to protect the proceedings and records of peer review committees in a manner in which medical and hospital associations have insisted is absolutely imperative if such committees ever can operate in an effective manner.

#### Malpractice Suit Protection

With the new act's effective date in June, peer review proceedings and records no longer will be subject to discovery (by subpoena or otherwise), nor will be admissible into evidence in any civil action which might arise out of matters subject to the review. This means they cannot be used in a malpractice suit.

In addition, persons in attendance at peer review committee meetings will not be allowed nor required to testify as to anything presented to the committee—nor to any opinion formed as a result of the peer review process.

Original records presently available in litigation (i.e., patients' records, hospital records, etc.) still will be discoverable. Witnesses with personal knowledge of events under review still may testify in court, but not—as indicated above—with respect to peer review proceedings.

An individual may waive this confidentiality as to his own acts or omissions, but cannot be forced to do so under the new enactment.

Peer review records may be reviewed by an appeal agency (i.e., another higher peer review body or by a court) in action attacking the original decision or recommendation of the peer review committee. The records then will be available to both sides—the individual under review and the peer review committee.

If the review is by a court, that court is authorized by the new law to protect the records from any further disclosure, by a step such as that requiring a sealed record of the proceedings.

The 1980 act will maintain the broad definitions of individuals subject to review, and of peer review organizations, included in the 1975 enactment.

In summary, the peer review process should be made more effective by the new legislation. There should no longer be a fear, for example, of the process potentially benefiting plaintiffs' attorneys. Discussion and decision-making now may be carried out without consideration of later disclosure.

## Eighteen New Family Physicians To Practice In State

By this summer, 44—or 76 per cent—of the 58 family physicians who have graduated from the five West Virginia programs will be practicing in state communities.

John L. Fullmer, M. D., of Morgantown, President of the West Virginia Chapter of the American Academy of Family Physicians, announced that 17 of the 22 doctors who will graduate this summer from the programs will practice in West Virginia communities. One other doctor who was trained in the Clarksburg program will also be returning to practice in rural West Virginia, bringing the total to 18.

The five three-year centers are located in Clarksburg, Huntington, Morgantown, South Charleston and Wheeling.

New family physicians will be opening offices in the following state communities: Clarksburg, Kingwood, Lewisburg, Madison, Moorefield,

Morgantown, Randolph County, South Charleston, St. George (Tucker County), and Wheeling.

While final figures are unavailable at this time, Doctor Fullmer noted that at least 21 new doctors will be beginning their residencies in the program this summer.

He also stressed the important training role that established family physicians in private practice throughout the state play in "allowing fourth-year medical students and residents to learn from them in a real-life setting."

The Clarksburg Family Practice Center will graduate one physician this summer. Dr. Sidney Jackson will practice in Clarksburg. Another family physician, Richard Jones, M. D., who took training at the center and who left the state has decided to come back and practice at St. George in Tucker County.

The Huntington Center will graduate two family physicians this year. Drs. Malcolm MacPherson-Smith and Gabriel Fornari will both be practicing out of state.

The Kanawha Valley Family Practice Center in South Charleston will graduate five this year. Their names and practice locations are: Drs. Michael B. McBride, Sarasota, Florida; Robert B. Atkins, Madison; T. Ray Perrine, South Charleston; Stephen L. Sebert, Lewisburg, and Donald F. Teter, South Charleston.

Morgantown graduates and their locations are: Drs. Edward Blume, Morgantown; Richard D. Gais, Morgantown; James E. Goodwin, Kingwood; R. Mark Jones, Randolph County; Jan E. Palmer, Morgantown; Thomas F. Peck, Moorefield; M. Bruce Vukoson, University of North Carolina, and Kaye T. Whitaker, Morgantown.

Wheeling graduates and their locations are: Drs. Terry Elliot, Wheeling; John R. King, Wheeling; Edward L. Emch, Wheeling area; Keith C. McLaughlin, Air Force; John J. Templeton, Wheeling, and Kelly D. Rutherford, Portland, Oregon.

## Doctor Cooke Honored

Dr. William L. Cooke of Charleston has been selected for the American Lung Association's 75th Anniversary Hall of Fame.

Doctor Cooke is one of 75 persons in the nation to be chosen, and will be inducted during dinner ceremonies at a meeting of the Association on May 20 in Washington, D. C.

He is a former President of both the state and national lung associations.

## MU Receives $1.6 Million Grant To Evaluate Vaccines

The National Institutes of Health (NIH) has designated Marshall University's School of Medicine as one of three research centers for evaluation of respiratory virus and bacterial vaccines, Dr. Robert W. Coon, MU Medical School Dean, announced recently.

The five-year contract, totaling approximately $1.6 million, is the largest research award the young school has received, according to the Dean.

As a NIH vaccine evaluation center, Marshall joins the University of Vermont, also a newly-established center, and Vanderbilt University, which has been studying vaccines for NIH for several years. Marshall and Vanderbilt will be evaluating vaccines for children while the University of Vermont will be testing vaccines for adults.

The study will be conducted by two members of the school's Department of Medicine. Dr. Robert B. Belshe, Associate Professor, and Dr. Lee P. Van Voris, Assistant Professor, who for the past two years have been working with area pediatricians in a vaccine study to immunize children against respiratory syncytial (RS) virus.

"The implications of the NIH-funded research will touch many lives in southern West Virginia," Doctor Coon said. "Being named an evaluation center is a feather in the school's cap, because we competed with several of this country's major and long-established schools with proven research capabilities."

### Opportunity for Children

"But, even more importantly, it means that children in this area will have an early opportunity to be immunized against many of the respiratory diseases," he noted.

"Our studies with the RS vaccine during the past two years have shown that there is a significant amount of respiratory—that is pneumonia or flu-like illness in children of this region," Doctor Belshe said. "In fact, the success of our RS vaccine study and the support it received from parents and pediatricians played a major role in our getting this contract," he added.

Describing the community as an "epidemiological island representative of middle America," Dr. Maurice A. Mufson, Chairman of the MU Department of Medicine, said that Huntington's relatively stable population base makes it ideal for such a study. "It's a neighborhood town

(Continued on next Page)

## Legislative Review To Cover Welfare Medical Program

The Legislature's standing Committee on Finance — acting in line with a State Medical Association recommendation—will make a detailed study of the Department of Welfare's Medical Services Program prior to next January.

The Medical Association's letter to the legislative leadership proposing such a study said, in part:

"In the light of the complex nature of this medical services activity—and a clear indication that the state well might be trying to provide an overall program it simply cannot afford—this Association strongly feels some future, specific guidelines should be developed by the Legislature.

"In particular, it seems logical that the Legislature should determine, in the light of the total fiscal responsibility it has, just what kind of program the state can afford, *and adequately fund* with customary levels of payment to providers."

The Medical Association stressed, in its letter to Senate President W. T. Brotherton, Jr., Kanawha County Democrat, that the main concern in any approach to the Medical Service Program must be quality and accessibility of care for those served by the welfare agency.

It noted that current problems in the medical program, including early difficulty in implementing a new computerized claims processing system, are causing providers in various areas of health care to cease participation. This, the Medical Association said, threatens to undermine the Medical Services Program itself if it is not put on a sound, long-range basis.

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MU RECEIVES—Continued

with all socio-economic groups represented. The fact that almost all births occur at Cabell Huntington or St. Mary's hospitals makes it easy for us to have an accurate count of the children in each age group," Doctor Mufson explained. "This, in turn, makes us able to better estimate the extent of a disease within the community and to determine the results of the vaccine."

The first study, slated to begin this spring, will probably be of a meningitis vaccine. "Meningitis continues to be a problem in young children in this community, as it is in all communities," Doctor Belshe said.

"We ought to stress that the vaccines we will be examining are not 'experimental,' but will have been field tested elsewhere previously," noted Doctor Van Voris, the co-researcher for the NIH program. "Unlike the RS vaccine, where we inoculated more than 500 children, the NIH studies will involve much smaller numbers of children—more like 20 or so per study," he explained.

# *Medical Meetings*

May 1-3—W. Va. Chapter, ACS, White Sulphur Springs.

May 5-8—Am. College of Obstetricians & Gynecologists, New Orleans.

May 7-10—Va. Society of Ophthalmol. & Otolaryngol., Inc., Williamsburg.

May 9-11—Am. College of Nuclear Med., Montreal.

May 10-15—Ohio State Med. Assn., Cincinnati.

May 13—Prematurity — Obstet. & Neonatal Update (Workshop by WVU School of Nursing, School of Med., etc.), Deep Creek Lake, Md.

May 15-18—ASIM, Washington, D. C.

May 17-23—Am. Gastroenterological Society, Salt Lake City.

May 18-21—Am. Thoracic Society, Washington, D. C.

May 18-22—Am. Urological Assn., San Francisco.

May 21—Prematurity — Obstet. & Neonatal Update (Workshop by WVU School of Nursing, School of Med., etc.), Martinsburg.

May 22—Allergy Immunotherapy: Scientific Basis & Practical Use, Elliott Ellis, M. D. (WVU Charleston Div.), Charleston.

May 23-24—W. Va. Affiliate, Am. Heart Assn., Harper's Ferry.

May 28—Prematurity — Obstet. & Neonatal Update (Workshop by WVU School of Nursing, School of Med., etc.), Morgantown.

June 15-17—Am. Diabetes Assn., Washington, D. C.

June 24-27—Society of Nuclear Med., Detroit.

July 20-24—AMA House, Chicago.

**Aug. 20-23—113th Annual Meeting, W. Va. State Assn., White Sulphur Springs.**

Sept. 8-10—Am. Neurological Assn., Boston.

Sept. 21-25—Am. College of Radiology, New Orleans.

Oct. 6-9—AAFP, New Orleans.

Oct. 17-19—AMA Regional Meeting, Huron, Ohio.

Nov. 2-7—Am. Academy of Ophthalmol., Chicago.

Nov. 12-15—Am. Heart Assn., Miami.

Nov. 14-16—AMA Regional Meeting, New York City.

**1981**

**Jan. 23-25—14th Mid-Winter Clinical Conference, Charleston.**

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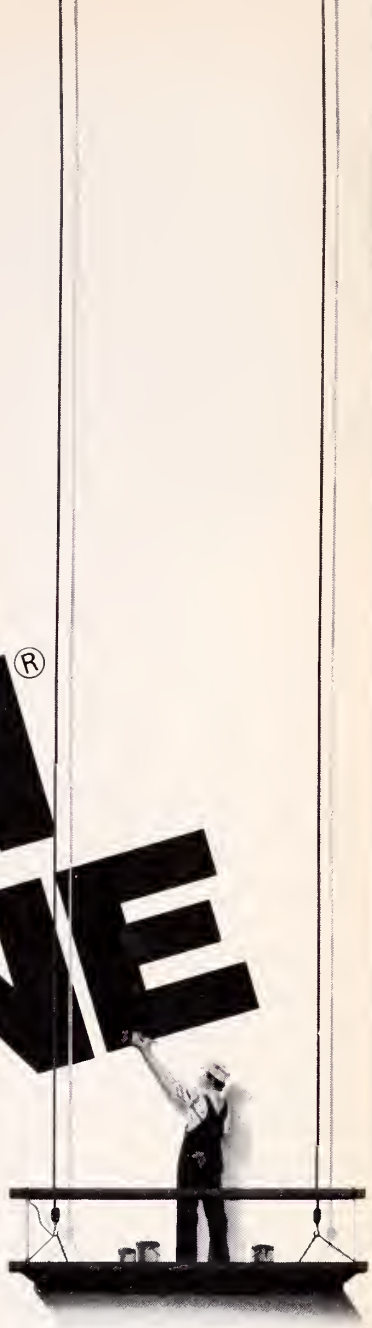

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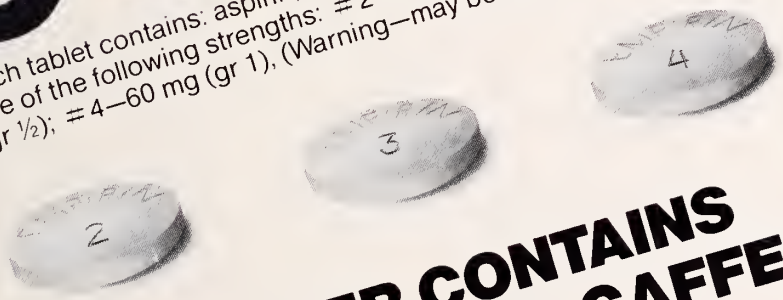


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**dual-action Triavil®**

**containing perphenazine and amitriptyline HCl**

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*Please see the following page for a brief summary of prescribing information.*

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4 mg perphenazine and 10 mg amitriptyline HCl.

**CONTRAINDICATIONS:** Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

**WARNINGS:** TRiAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

**PRECAUTIONS:** Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

**Perphenazine:** Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

**Amitriptyline:** In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

**ADVERSE REACTIONS:** Similar to those reported with either constituent alone.
**Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia. antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema, reversed epinephrine effect, hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement, hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

**Amitriptyline:** Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia, palpitation; myocardial infarction; arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement, anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia, tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria, photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea, parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female, increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

**OVERDOSAGE:** All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

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# WVU Medical Center
# –News–

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## New Poison Control System Based In Charleston

Prevention of accidental poisoning through education—as well as guiding the treatment of poison victims—is a major goal of the new West Virginia Poison Control System based in Charleston.

Operated by the West Virginia University School of Pharmacy, the facility serves as a poison information center for southern, central and eastern West Virginia, recommending treatment to both health professionals and the public. But its service is not limited to the treatment information given to those who call its toll-free number.

By spreading the word on poison prevention to health professionals, day care centers, elementary teachers, volunteer groups and service organizations, the system hopes its message will be carried on to the general public. Member hospitals in the system also will assist with education programs in their areas.

"We want to educate the educators," said Kathy Sensabaugh, nurse educator and Assistant Director of the system, "and to emphasize prevention."

"But the public needs to know of our existence, what our resources are and how to reach us in the event of an emergency involving a toxic substance."

### Six Poison Specialists

The center is located in the Charleston Division of the WVU Medical Center. When it reaches full operation, it will employ six nurses or pharmacists as poison specialists.

John F. Tourville, Pharm.D., Assistant Professor of Clinical Pharmacy, is the Acting Director. Robert H. Hoy, Pharm.D., Assistant Professor of Pharmacy in the Charleston Division, and other members of the WVU pharmacy faculty serve as resource persons and educators.

The system was established by contract with the West Virginia Department of Health, with proportionate amounts of the costs being paid by the three emergency medical services regions which operate in the 29-county area.

The Mountain State Poison Control Center, which is operated by University Hospital in Morgantown and the Department of Pediatrics in the WVU School of Medicine, will continue to serve Northern Panhandle and other northern counties as a poison control center. The existing poison control center at St. Mary's Hospital in Huntington will become part of the Charleston-based system, but will retain its present toll-free telephone number.

Both the West Virginia Poison System and the Mountain State Center are satellites of the National Poison Network's regional center in Pittsburgh. As such, both are able to distribute "Mr. Yuk," a symbol denoting poison for children who cannot read, and educational packets on poison prevention.

In addition, the national network provides access to a computerized data system, monthly statistical reports, seminars, continuing education courses and newsletters concerning most frequent or new causes of poisoning and recently developed methods of treatment.

### Plant Ingestion Most Frequent

Calls concerning children who have eaten parts of house plants are now the most frequent, although plant ingestion is not generally the most serious, Ms. Sensabaugh noted. Most plant ingestion involves irritation of tissues in the mouth and throat rather than systemic poisoning, but all cases should be discussed with a poison specialist.

The most frequent calls where systemic poisoning is a factor involve overdoses of common drugs such as aspirin or Tylenol or other over-the-counter and prescription medications.

Although children under five are the most likely victims of accidental poisoning, adults frequently misuse toxic substances.

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# Third-Party News, Views and Program Concerns

## Republicans Backing New Catastrophic Plan

Top House Republicans are now backing a new catastrophic national health insurance plan. House Minority Leader John Rhodes of Arizona and Rep. James Martin of North Carolina, Chairman of the House Republican Task Force on Health Policy, say their Medical Expense Protection Act of 1980 is a two-pronged approach designed to improve health coverage under voluntary private plans; and to provide catastrophic protection for all people not covered by a plan or by a public program.

A formula in the bill provides that once medical bills reach a certain percentage of income, all further expenses are automatically assumed by the program.

"Our goal is to encourage employers and the health insurance industry to provide proper coverage at reasonable costs so that the Federal Government can concentrate on providing coverage for those unable to obtain their own, at a minimum total cost to the taxpayer." Martin said.

Estimated first-year cost of the bill was set at $7 billion, compared to $24 billion for President Carter's health plan, and $50 billion for Sen. Edward Kennedy's approach.

Under the bill, private health insurance plans would be required to meet certain standards or lose their tax deductibility. The standards include minimum levels of catastrophic coverage, minimum employer premium contributions and certain types of coverage requirements.

"This approach, involving federal funds only when protection otherwise is not available, and only when expenses for a family are heavy relative to income, will entail less government intrusion and provide more benefits at lower costs than plans relying more heavily on government participation," Martin said.

Seventeen other House members have joined Rhodes and Martin in sponsoring the bill. A somewhat similar catastrophic plan is being considered by the Senate Finance Committee.

## Court Says No Constitutional Right To Laetrile

A federal appeals court has written a concluding chapter on laetrile, holding that terminally-ill patients have no constitutional right to the drug regardless of federal law.

The U. S. Supreme Court ruled last summer that dying patients are not entitled to an exemption from the government's laetrile ban, but sent the case back to the 10th Circuit Court of Appeals in Denver, Colorado, to consider constitutional and statutory questions.

The appeals court said "the decision by the patient whether to have a treatment or not is a protected right, but his selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health."

## Medical Examiners Needed

The Workmen's Compensation Act (Code 23-4-7a) mandates that whenever a claimant's temporary total disability continues longer than 120 days, the Commissioner shall refer the claimant for an independent medical examination and evaluation.

The absence of qualified examiners in some areas of the state is creating considerable hardship upon some claimants. They quite often have to travel many miles to the closest examiner for evaluation and sometimes have to wait months for an appointment.

Physicians specializing in the field of general surgery, orthopedics, neurosurgery, and eye, ear, nose, and throat are immediately needed in order that the Workmen's Compensation Fund's Medical Division can establish a state-wide roster of examiners.

For additional information, interested physicians are requested to contact Mr. Joseph I. Stone, Administrative Assistant, Claims Processing, West Virginia Workmen's Compensation Fund, State Capitol, Charleston, West Virginia 25305; telephone 348-5940.

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Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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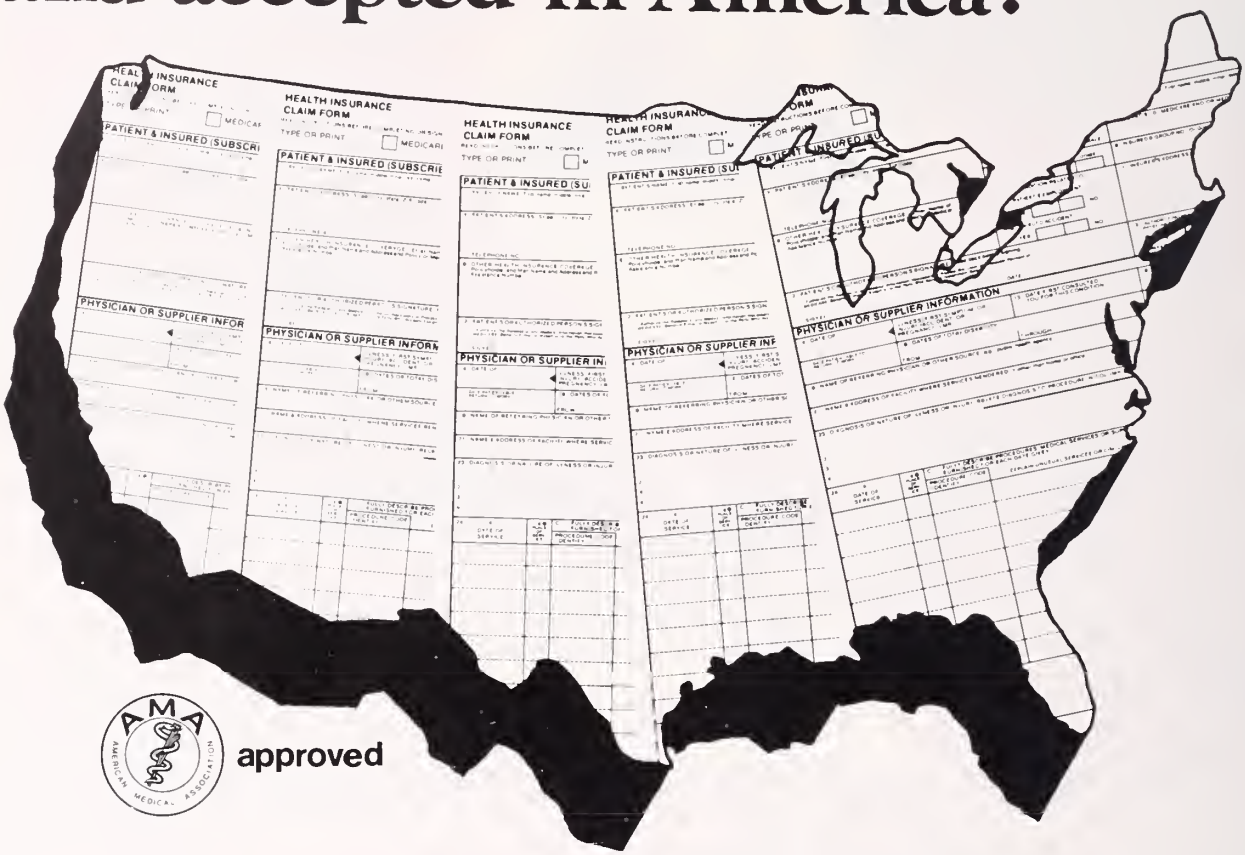


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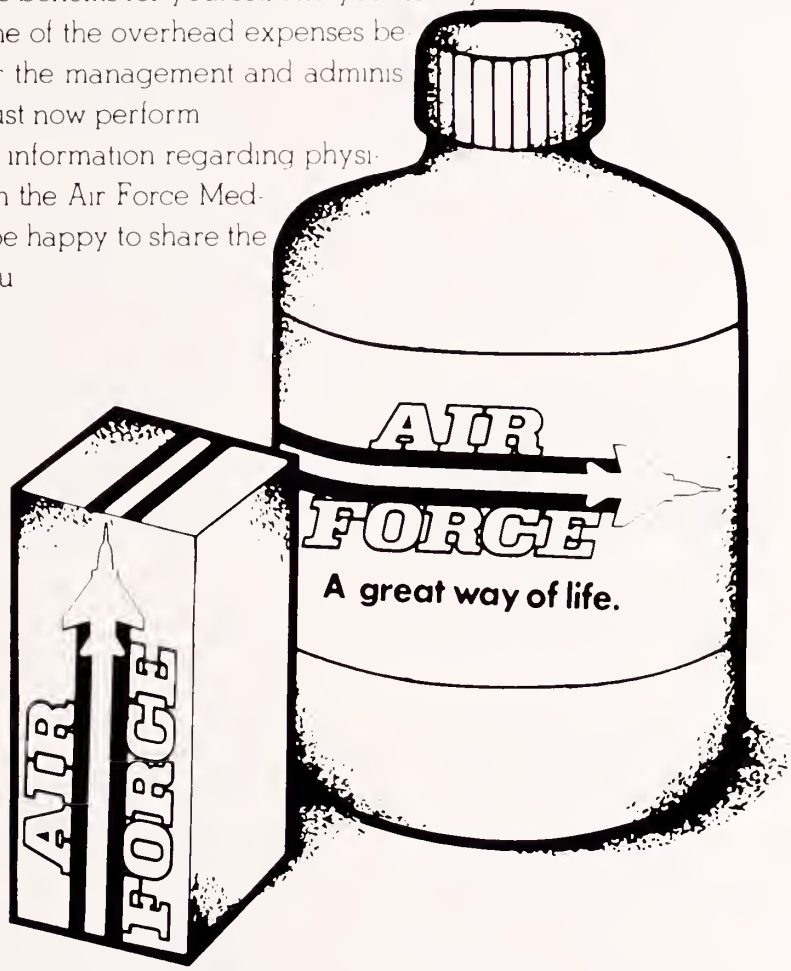


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## Obituaries

### SHERL J. WINTER, M. D.

Dr. Sherl J. Winter, retired Beckley pediatrician, died on March 24 in a hospital there. He was 78.

Doctor Winter had practiced in Beckley since 1955, when he came there from a tour of duty with the U. S. Navy in Swarthmore, Pennsylvania, to work with the medical program of the United Mine Workers Welfare and Retirement Fund and serve as Chief of Dependents at the former Beckley Memorial Hospital (now Beckley Appalachian Regional Hospital).

He also helped establish the Mountaineer Family Health Plan, and served as its Medical Director until his retirement for health reasons in August, 1970.

Doctor Winter also served as pediatric consultant for Mullens General Hospital.

A native of Pershing, Indiana, he was graduated from Indiana University and received his M. D. degree in 1926 from that institution's School of Medicine. He interned at St. Elizabeth Hospital in Dayton, Ohio, and took his residency at Babies and Childrens Hospital in Cleveland, Ohio.

Doctor Winter was a member of the Raleigh County Medical Society, West Virginia State Medical Association, American Medical Association, and American Academy of Pediatrics.

He served two tours of duty with the Navy—1942 to 1945 and 1947 to 1955.

Survivors include the widow; one son, Sherl Joseph Winter of Philadelphia; and one daughter, Miss Genevieve Anne Winter, at home.

* * *

### IVAN H. BUSH, M. D.

Dr. Ivan H. Bush of Oak Hill died on March 30 in a hospital there. He was 67.

Doctor Bush specialized in internal medicine and pediatrics.

A native of Glenville, he was graduated from Glenville State College, and also earned M. S. and B. A. degrees at West Virginia University. He received his M. D. degree in 1950 from the University of Virginia Medical School, and completed his internship and residency at the University's Hospital.

Doctor Bush was a member and Past President of the Fayette County Medical Society; a member of the West Virginia State Medical Association and the International College of Angiology; a Fellow of the American Geriatric Society, and a former President of the Fayette County Tuberculosis Association.

He was a World War II Navy veteran.

Survivors include the widow; three sons, John P. Bush of Annapolis, Maryland; Richard S. and Michael J. Bush, both of Oak Hill; a daughter, Virginia E. Bush of Oak Hill; two brothers, A. Kyle Bush, M. D., of Philippi and Waitman N. Bush of Falls Church, Virginia, and one sister, Mrs. Marjorie Given of Strange Creek (Braxton County).

* * *

### EARL S. PHILLIPS, M. D.

Dr. Earl S. Phillips of Wheeling, a general practitioner, died on March 7 in a hospital there. He was 82.

Doctor Phillips was an honorary member of the Ohio County Medical Society, West Virginia State Medical Association and American Medical Association.

A native of Spraggs, Pennsylvania, he was graduated from West Virginia University and received his M. D. degree in 1924 from Jefferson Medical College. He interned at Philadelphia (Pennsylvania) General Hospital.

Survivors include the widow and two sons, G. Richard Phillips of Morgantown and Dr. Frederick Phillips of Fredericksburg, Virginia.

* * *

### JOHN S. BLAGG, M. D.

Dr. John S. Blagg of South Charleston, a family physician, died on April 8. He was 61.

Doctor Blagg was President of the West Virginia Society of Clinical Hypnosis.

A native of South Charleston, he was graduated from the University of Louisville and received his M. D. degree in 1948 from the Medical College of Virginia. He interned at Charleston General Hospital.

Doctor Blagg, who served with the U. S. Army Medical Corps during the Korean War, was a member of the Kanawha Medical Society, West Virginia State Medical Association, American Medical Association and American Society of Clinical Hypnosis.

Survivors include the widow; two daughters, Mrs. Nancy Kenish of Columbus, Ohio, and Mrs. Susan Weaver of South Charleston; a brother, Benjamin V. Blagg, Jr., of Annapolis, Maryland, and a sister, Mrs. Liza Burlingame of Texas.

## LOGAN

The Logan County Medical Society met on March 12 at Logan General Hospital.

Dr. K. V. Raman of Huntington, Clinical Associate Professor of Surgery at Marshall University School of Medicine, was the speaker for the evening. His subject was carotid artery disease, with an emphasis on non-invasive diagnostic techniques. The discussion period also covered diagnostic approach to deep vein thrombosis.—Herbert D. Stern, M. D., Secretary.

* * *

## McDOWELL

Dr. Henry M. Bellamy, Jr., Beckley gastroenterologist, was the guest speaker for the meeting of the McDowell County Medical Society on March 12 at Stevens Clinic Hospital in Welch.

Doctor Bellamy's subject was diagnosis and treatment of colitis.

The Society drafted and approved a letter which was sent to the McDowell County Health Education Project in support of its efforts to get an obstetrician-gynecologist in the County.

Another Society letter also was approved and sent to the McDowell County Health Action Council in support of the Council's efforts to obtain supplementary funding from the McDowell County Commission for the Health Education Project.—Muthusami Kuppusami, M. D., Secretary.

* * *

## FAYETTE

The Fayette County Medical Society met on March 5 at Montgomery General Hospital.

The guest speaker was Robert Baker, attorney and Director of the Fayetteville Appalachian Research and Defense Fund Office. Mr. Baker discussed medical reports for Social Security disability.—Daniel B. Doyle, M. D., Secretary.

* * *

## CABELL

The Cabell County Medical Society met on March 13 at the Holiday Inn Gateway in Barboursville.

Dr. William Davis of the Baby's Hospital of Columbia Presbyterian Medical Center in New York City was the guest speaker. He presented an informative and well-organized discussion on asthma.

Dr. Albert C. Esposito summarized a measure recently passed by the West Virginia Legislature regarding non-physician majorities on medical service (Blue Shield) corporation boards. — Charles E. Turner, M. D., Secretary.

* * *

## MARION

The Marion County Medical Society and the Marion County Bar Association held a joint meeting on March 20 at the Elks Club in Fairmont. Judge Robert C. Halbritter of the Preston County Circuit Court delivered a talk concerning the role of the physician as a witness in civil litigation.—William L. Mossburg, M. D., Secretary.


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S. O. Chung, M. D.
J. E. Cunningham, D. O. (Mount Storm & Riverton Clinics)
M. C. Rosenberg, D. O. (Helvetia Clinic)
L. E. Soriano, M. D. (Marlinton Clinic)
P. M. Tanna, M. D. (Green Bank Clinic)

**EMERGENCY MEDICINE:**
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A. M. Fuller, M. D.
F. A. Khan, M. D.

**FAMILY PRACTICE:**
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H. E. W. Gregor, M. D.

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H. L. Jellinek, M. D.
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F. Becerra, M. D.
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J. F. de Courten, M. D.
J. J. Rizzo, M. D.

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**PEDIATRICS:**
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R. J. Haas, M. D.

**RADIOLOGY:**
F. H. Abdalla, M. D.
H. Y. Mang, M. D.
C. P. O'Sullivan, M. D.

**SURGERY:**
**General, Thoracic & Vascular:**
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W. B. Blum, M. D.
B. R. Blackburn, M. D.

**UROLOGY:**
D. T. Chua, M. D.

# Book Review

**THE COURAGE TO LIVE**—Ari Kiev, M. D. 148 pages. Price $7.95. Thomas Y. Crowell, Publishers, 10 East 53rd Street, New York, New York 10022. 1979.

This book is not a highly technical medical treatise intended for doctors, but is a very readable small book directed at depressed people and their families. This means that there is a large readership for the book in America today. The author points out that perhaps as many as a quarter million Americans are so depressed that they attempt or contemplate suicide each year. He also mentions that "the depressed person is in good company. Abraham Lincoln, Nathaniel Hawthorne, Winston Churchill, astronaut Buz Aldrin and even Sigmond Freud suffered from severe depression."[1]

Doctor Kiev's book is a message of good hope for this audience. Being aimed particularly at those people who are so depressed that they consider suicide, it says, "if you have the courage to die as you choose, you should have the courage to live as you choose."[2] He goes on to state that the person who is considering suicide is unhappy with his life and his work. As a matter of fact, he likes what he is doing so little that he is willing to die not to do it. It is the role of the therapist to help this individual to determine what it is in life that he dislikes so much and then to help him decide not to do those things anymore. He should be led to find a new life filled with things that he does like to do. In the first six chapters, Doctor Kiev amplifies this theme, pointing out the usefulness of chemotherapy in the early stages of depression and the necessity of psychotherapy to complete the healing process.

The latter part of the book deals more specifically with recommendations for physicians or therapists who are working with the depressed, giving rather specific suggestions as to how to handle suicide telephone calls, and crisis situations.

Doctor Kiev points out that frequently, for the depressed, the crisis will occur on holidays or weekends. He says, "For the lonely and depressed the weekend waits like a fearsome, shapeless specter." Perhaps our holidays and weekends do not have such a foreboding appearance, but if we are bored with a weekend this is a book which can be read enjoyably in one evening.—T. Keith Edwards, M. D.

1. Page 89.
2. Page 2.

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**ONE HUNDRED YEARS OF PHYSIOLOGY AT WEST VIRGINIA UNIVERSITY, 1869-1969**—Edward J. Van Liere, Ph.D., M. D. 124 pages. Price $10. West Virginia University Foundation, Morgantown, West Virginia, 1979. McClain Printing Company, Parsons, West Virginia.

It is very difficult to review a book which is written by an author who has been held in high regard for many years. Doctor Van Liere's long career as Professor and Chairman of the Department of Physiology at the School of Medicine of West Virginia University from 1921-1955; Dean of the West Virginia School of Medicine from 1935-1966, and member of *The West Virginia Medical Journal* Editorial Board has made him a legend.

His book describes how and by whom a course in physiology was taught for 100 years, 1869-1969, at the West Virginia University School of Medicine. Doctor Van Liere also gives a brief history of physiology. He goes into detail to describe how staff members are appointed, how the Department of Physiology was housed, how laboratory manuals were developed, and how animal quarters were used and abused. The bulk of his book gives biographical sketches of teachers in the physiology department. One of the five-part appendices describes why he became a professional physiologist.

It is unfortunate that this book was not written 10 years earlier. As a result, interest in this book will be limited to those who were closely involved with the Department of Physiology at that time. It is written in a hodge-podge style and tends to be repetitive in places. I believe that hearing Doctor Van Liere give an oral history of the Department of Physiology would have been more fascinating.—W. F. Daniels, M. D.


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## Urology President

Dr. Stanley J. Kandzari of Morgantown was elected President of the West Virginia Urological Society at a March meeting of the Society in Charleston. Dr. John A. Belis, also of Morgantown, was elected Secretary-Treasurer.

Doctor Kandzari is Professor of Urology at West Virginia University School of Medicine.

The next meeting of the Society will be held on August 22 at the Greenbrier in White Sulphur Springs in conjunction with the 13th Annual Meeting of the State Medical Association (August 20-23).


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| Society | President | | Secretary | | Meetings |
|---|---|---|---|---|---|
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| Brooke | Rogelio L. Velarde | Follansbee | Wm. T. Booher, Jr. | Wellsburg | |
| Cabell | Harry K. Tweel | Huntington | Charles E. Turner | Huntington | 2nd Thurs. |
| Central West Virginia | John A. Mathias | Buckhannon | Joseph B. Reed | Buckhannon | As Sched. |
| Eastern Panhandle | Harvey D. Reisenweber | Martinsburg | Orlando I. Agnir | Martinsburg | 2nd Wed. |
| Fayette | Lewis A. Cook | Fayetteville | Daniel B. Doyle | Oak Hill | 1st Wed. |
| Greenbrier Valley | Robert K. Modlin | Ronceverte | Robert K. Scott II | Ronceverte | 2nd Wed. |
| Hancock | Carlos L. Vasquez | Weirton | Pedro R. Montero, Jr. | Weirton | 3rd Tues. |
| Harrison | Louis C. Palmer | Bridgeport | Victorino D. Chin | Bridgeport | 1st Thurs. |
| Jefferson | L. Mildred Williams | Charles Town | Vittivelu Maheswaran | Charles Town | 1st Wed. |
| Kanawha | James W. Lane | Charleston | Thomas J. Janicki | Charleston | 2nd Tues. |
| Logan | Abelard A. Pelaez | Logan | Herbert D. Stern | Logan | 2nd Wed. |
| Marion | Charles E. Haislip | Fairmont | Wm. L. Mossburg | Fairmont | Last Tues. |
| Marshall | Erol Bastug | Glen Dale | J. T. Ho | Moundsville | 1st Tues. |
| Mason | Montrie Chaksupa | Point Pleasant | Richard L. Slack | Point Pleasant | 4th Tues. |
| McDowell | Ross M. Patton | Gary | M. Kuppusami | Welch | 2nd Wed. |
| Mercer | Edward M. Spencer | Bluefield | David F. Bell, Jr. | Bluefield | 3rd Mon. |
| Mingo | William H. Carter | Williamson | Edward B. Headley | Delbarton | 2nd Wed. |
| Monongalia | Barbara Jones | Morgantown | Richard S. Kerr | Morgantown | 1st Tues. |
| Ohio | Basil P. Papadimitriou | Wheeling | Robert L. Joseph | Wheeling | 4th Tues. |
| Parkersburg Academy | Robert F. Gustke | Parkersburg | Billie M. Atkinson | Parkersburg | 1st Thurs. |
| Potomac Valley | Howard J. Maxwell | Petersburg | Sadtha Surattanont | Romney | 2nd Wed. |
| Preston | John W. Trenton | Kingwood | C. Y. Moser | Kingwood | 4th Thurs. |
| Raleigh | Prospero B. Gogo | Beckley | Richard D. Richmond | Beckley | 3rd Thurs. |
| Summers | T. H. Mirza | Hinton | Chandra P. Sharma | Hinton | 3rd Mon. |
| Tygart's Valley | A. Kyle Bush | Philippi | Michael M. Stump | Elkins | 3rd Thurs. |
| Wetzel | K. M. Chengappa | New Martinsville | Donald A. Blum | New Martinsville | Monthly |
| Wyoming | George F. Fordham | Mullens | Frank J. Zsoldos | Mullens | Quarterly |

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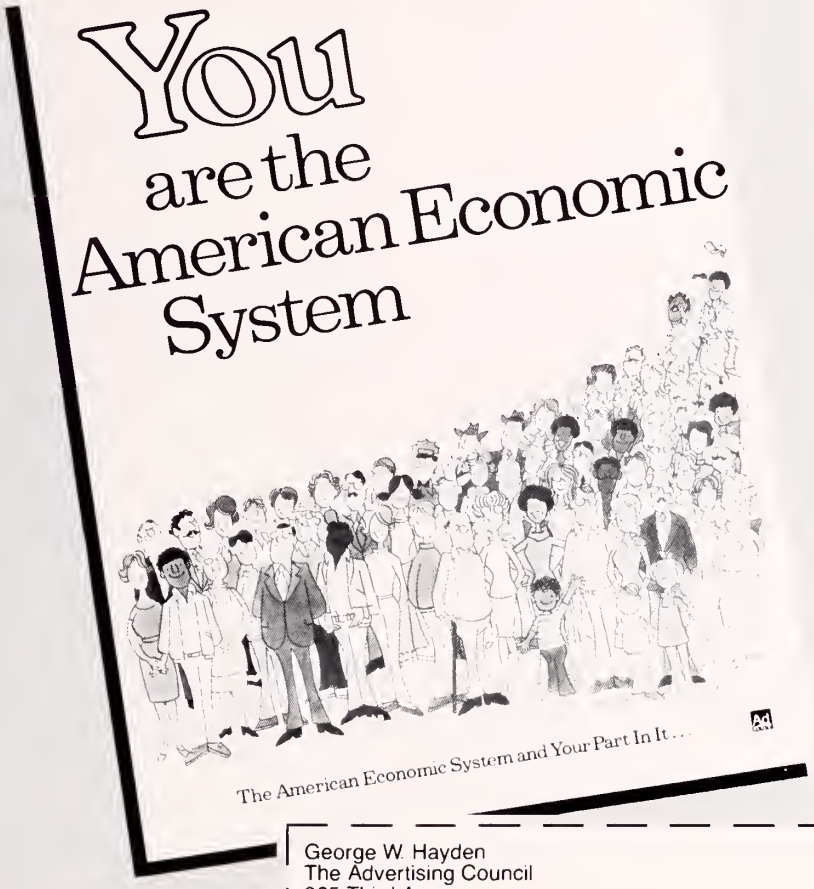


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Golden Clinic, The xx

Harding Hospital, The xxviii

Kanawha Valley Bank, N.A. xxii

Lilly, Eli, and Company xii

McDonough Caperton Shepherd Association Group xv

Merck Sharp & Dohme *Insert*

Myers Clinic, The xxii

Pathology Associates Laboratory vii

Prince Medical Reference Laboratories xiii

Roche Laboratories ii, iii, iv, viii, ix, *Insert*, *Inside Back Cover*, *Back Cover*

Rorer, William H., Inc. *Insert*

Schering Corporation x, xi

Smith Kline & French Laboratory Company A Smith Kline Company *Insert*

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**Indications:** Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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# The West Virginia Medical Journal

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# CONTENTS

## Scientific Articles

TRAUMATIC LACERATION OF THE PLACENTA — Firooz Ravangard, M. D.; and Charles V. Porter, M. D. 125

PREGNANCY FOLLOWING JEJUNOILEAL BYPASS — D. Martinez, M. D.; G. J. Mouhlas, M. D.; and F. G. Giustini, M. D. 130

MYELOFIBROSIS-POLYCYTHEMIA SYNDROME ON CONGENITAL HYPOPLASTIC ANEMIA: A CASE REPORT — Wilk O. West, M. D. 134

NOT ALL SADNESS CAN BE TREATED WITH ANTIDEPRESSANTS—David M. Morgan, M. D. 136

## The President's Page

CRAZY FEELINGS—Stephen D. Ward, M. D., President, W. Va. State Medical Association 138

## Editorials

MEDICAID PROBLEMS 139

DARK CLOUDS 140

QUALITY FIRST 141

## General News

113TH ANNUAL MEETING 142

ASSOCIATION HONORS FORMER HEALTH DIRECTOR 143

WVU GRADUATES' RESIDENCY SELECTIONS 145

MU CME COORDINATOR NAMED 146

APPLICANT SUPPLY SEEN AS COMING PROBLEM 147

ASSOCIATION DUES HIKE SOUGHT 148

INSURANCE PROPOSAL RECEIVED BY COUNCIL 148

WVU CME PROGRAM REACCREDITED 149

FEMALE GENITAL TRACT WORKSHOP JUNE 13-14 149

## Special Departments

WVU MEDICAL CENTER NEWS xii

THIRD-PARTY NEWS, VIEWS, PROGRAM CONCERNS xiv

OBITUARIES xvi

COUNTY SOCIETIES xvii

1979 ANNUAL AUDIT xx

CLASSIFIED SECTION xxii

INDEX TO ADVERTISERS xxiv

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**CONTRAINDICATIONS** Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants

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Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure, monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section)

**WARNINGS** Antihistamines should be used with considerable caution in patients with narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction

Use in Children. In infants and children especially antihistamines in overdosage may cause hallucinations, convulsions, or death

As in adults, antihistamines may diminish mental alertness in children In the young child, particularly, they may produce excitation

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE

Use in Pregnancy Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.)

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc

Use in the Elderly (approximately 60 years or older) Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients

**PRECAUTIONS** Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension

**DRUG INTERACTIONS** MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines

**ADVERSE REACTIONS** The most frequent adverse reactions are underlined

*General* Urticaria drug rash, anaphylactic shock photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat

*Cardiovascular System* Hypotension, headache, palpitations, tachycardia, extrasystoles

*Hematologic System* Hemolytic anemia, thrombocytopenia agranulocytosis

*Nervous System* Sedation sleepiness dizziness disturbed coordination, fatigue, confusion restlessness, excitation, nervousness, tremor, irritability, insomnia euphoria paresthesias, blurred vision, diplopia vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

*Gastrointestinal System* Epigastric distress anorexia nausea, vomiting, diarrhea, constipation

*Genitourinary System* Urinary frequency difficult urination, urinary retention, early menses

*Respiratory System* Thickening of bronchial secretions tightness of chest and wheezing, nasal stuffiness

**OVERDOSAGE** Antihistamine overdosage reactions may vary from central nervous system depression to stimulation Stimulation is particularly likely in children Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur

If vomiting has not occurred spontaneously, the patient should be induced to vomit This is best done by having him drink a glass of water or milk after which he should be made to gag Precautions against aspiration must be taken, especially in infants and children

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand Isotonic and ½ isotonic saline is the lavage solution of choice

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content

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# An added complication... in the treatment of bacterial bronchitis*

**Brief Summary.**
**Consult the package literature for prescribing information.**

**Indications and Usage:** Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

**Contraindication:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefcor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

*Usage in Pregnancy*—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

*Usage in Infancy*—Safety of this product for use in infants less than one month of age has not been established.

**Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

**Ceclor®**
**cefaclor**

Pulvules®, 250 and 500 mg

**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

*Hepatic*—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

*Note:* Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

**References**


1. Antimicrob. Agents Chemother., *8*:91, 1975
2. Antimicrob. Agents Chemother., *11*:470, 1977
3. Antimicrob. Agents Chemother., *13*:584, 1978
4. Antimicrob. Agents Chemother., *12*:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandelf, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979


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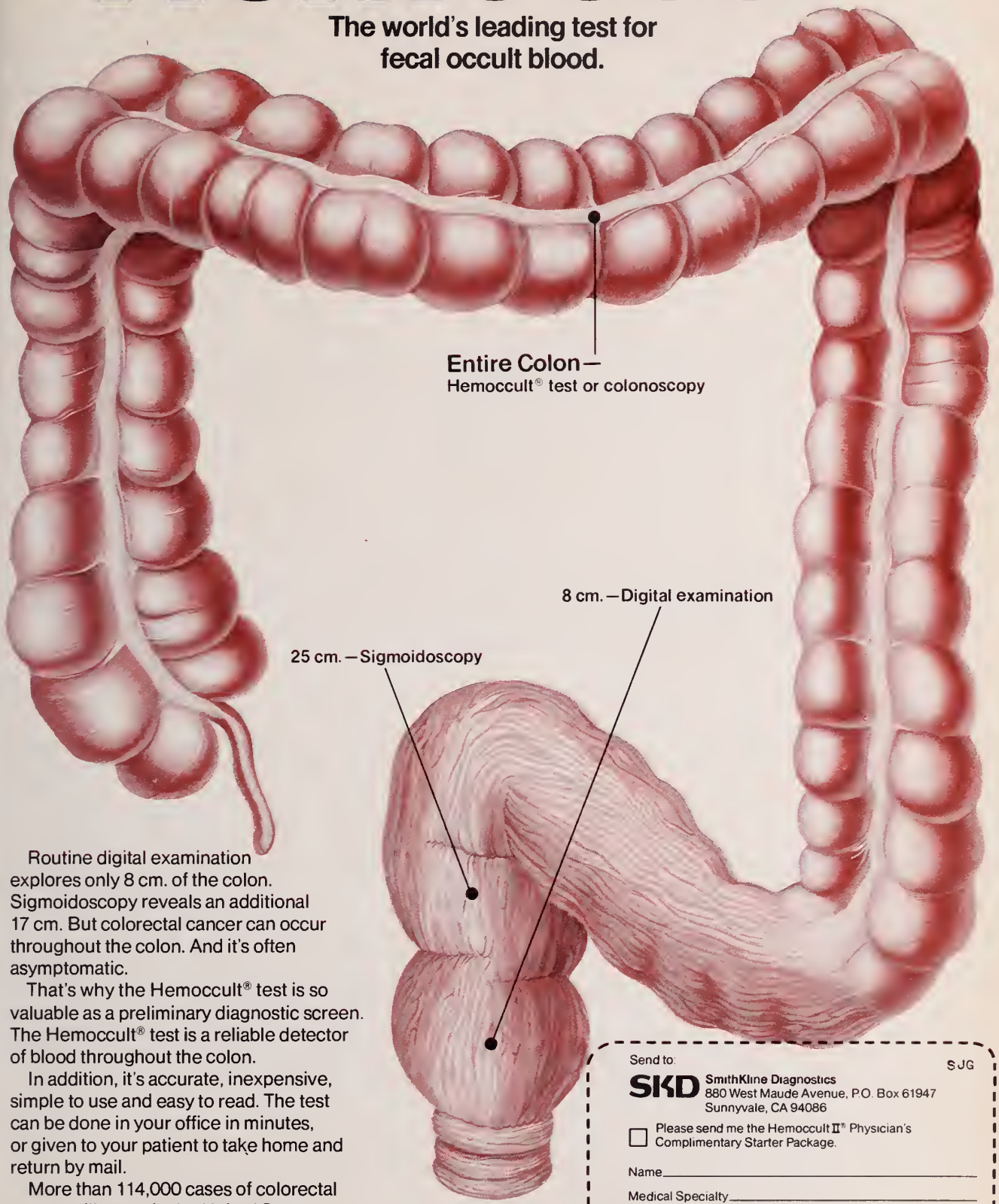


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INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours) reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

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**EQUAGESIC—Abbreviated Summary**

*INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.
"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation
The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

**CONTRAINDICATIONS**: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

**WARNINGS**: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g , alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination

**USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug**

**Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered**

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

**PRECAUTIONS**: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

**ADVERSE REACTIONS**: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

**OVERDOSE**. Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

**DESCRIPTION** Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

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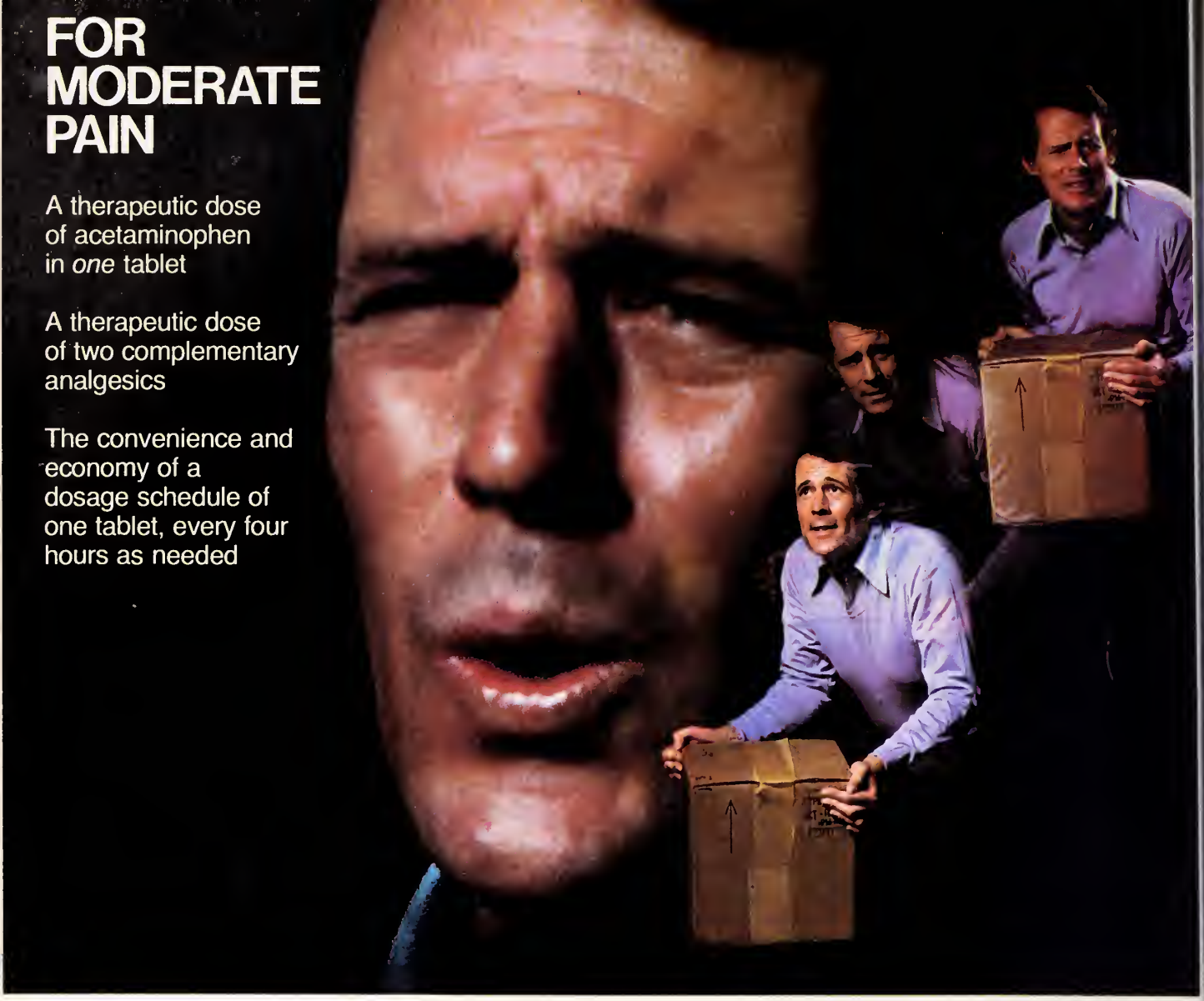
# FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



# WHY NOT WYGESIC® C IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

**WYGESIC—Abbreviated Summary**
**INDICATION**: For the relief of mild-to-moderate pain
**CONTRAINDICATION**: Hypersensitivity to propoxyphene or to acetaminophen
**WARNINGS**: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Manegement of Overdosege**).
**DRUG DEPENDENCE**: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
**USAGE IN AMBULATORY PATIENTS**: Propoxyphene may impair the mental and or physical abilities required for potentially hazardous tasks, e g driving a car or operating machinery Patients should be cautioned accordingly
**USAGE IN PREGNANCY**: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards
**USAGE IN CHILDREN**: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group
**PRECAUTIONS**: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol
**ADVERSE REACTIONS**: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
**DRUG INTERACTIONS**: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine
**MANAGEMENT OF OVERDOSAGE**: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal
**TREATMENT**: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient s condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness Appropriate literature should be consulted for further information. (JAMA 237 2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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# Traumatic Laceration Of The Placenta

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*Laceration of the placental vasculature resulting from automobile accident has been reported on few occasions. This case is an example of the laceration of the placental vessels and intrauterine fetal demise secondary to exsanguination into the amniotic fluid without significant injury to maternal structures.*

Accidental injury and death have been called "the neglected disease of modern society." Though the pregnant patient is exposed to the usual injuries, the intrauterine pregnancy creates a unique situation. Two lives are involved whose sensitivity to the effects of trauma are varied.[1] The accidental death rate during pregnancy has been reported to be between six and seven per cent.[2] In California, automobile fatalities caused 13.9 per cent of all maternal deaths[6] and, in Minnesota, the automobile was the most frequent non-obstetrical cause of maternal death.[6]

Blunt trauma is more common than penetrating trauma in civilian life and accounts for approximately 80 per cent of all abnormal injuries. The automobile accident is the causative agent in from 50 to 85 per cent of the cases.[1,3,4,5] Crosby and Costiloe reported a series, followed retrospectively, of 441 pregnant victims of automobile collisions. There were 15 maternal deaths (3.4 per cent).[3,6,7] The underlying causes of perinatal death from a study of 53,518 pregnancies in the United States were due to trauma to gravid uterus in 0.3 per cent of the cases.[10] Injury and death from car accidents are becoming an increasing problem in modern-day society. The pregnant woman and her fetus are not immune to such risk.

The assumption that causal relation exists between external trauma and interruption of pregnancy can be traced to antiquity, when it was recorded by the Assyrians as early as the 8th Century B.C. Diddle was able to trace this concept through the ages and different cultures to the present.[1,8]

Maternal accidental injury, even though not catastrophic, can alter the course of pregnancy. The fetus can be injured *in utero* as the result of trauma. The placenta, cord or membranes can be damaged, or maternal injury can cause severe alterations in maternal homeostasis (hypotension and hypoxia) that severely compromise the fetus. Abruptio placenta and psychologic shock secondary to maternal trauma appear to play a nonspecific role.[2] Catecholamines released during the acute stress of traumatic injury may produce marked reduction in uterine blood flow even though the maternal blood pressure may be actually higher than before stress.[6]

### Blunt Trauma

Severe fetal injury can result from blunt trauma even in the absence of uterine injury or rupture. A review of the current literature reveals skull fractures and intracranial hemorrhage to be the most common fetal injury resulting from trauma. Theurer and Kaiser, in 1963, reported six cases of severe fetal injury with an intact uterus which resulted in intrauterine death. In all six cases the fetal injury was localized to the head.[1-9]

The degree of fetal injury is related to the force of the trauma and the duration of gestation. Fetal injury is most likely to result in later pregnancy when buffering effect of the amniotic fluid is diminished. Experimental studies have

revealed that a force of 10.3 kilograms is required to fracture a fetal tibia and fibula.[1]

Crosby and Costiloe reported that the leading single cause of fetal death was death of the mother. When the mother survived, placental separation was the most frequent cause of fetal death.

The placenta, membranes and cord can be injured as a result of blunt injury. Although isolated injuries of these structures are rare, they present confusing clinical pictures. Injury to the placenta, membranes or cord may be severe enough to interrupt the pregnancy without directly involving the fetus.

Laceration of the placental vasculature resulting from automobile accident has been reported on four occasions. This case is an example of the laceration of the placental vessels and intrauterine fetal demise secondary to exsanguination into the amniotic fluid, without significant injury to maternal structures.

### Case Presentation

A 19-year-old white female, Gravida III, Para II, 36 weeks' gestation, was involved in a head-on collision with another car on October 24, 1977. She was sitting in the right front seat and was not wearing any type of seat belt restraint. This patient was brought into the emergency room 30 minutes after the accident. The patient was alert, responsive, and not in shock. She had a 15-cm. laceration of the extensor surface of the right forearm just below the elbow. The muscle was bulging, contused, and edematous. There also was a 3 x 3-cm. abrasion over the right upper quadrant.

The patient stated she was thrown forward, hitting her abdomen on the dashboard. Vital signs were blood pressure of 90/60 and pulse, 96. She was not feeling any pain or contractions. Her abdomen was soft, without tenderness. The size of the uterus measured 30 cm. and the abdomen was marked for future reference. Uterine contractions could be palpated every two minutes with their duration lasting 30 seconds. No fetal heart tones were audible. Pelvic examination revealed cervical dilatation of two cm., effacement 70 per cent, station floating. There was no vaginal bleeding or loss of fluid. The fetus was in cephalic presentation. The patient had felt no fetal movement since the accident. Her hematologic survey was as follows: hemoglobin, 11.3; hematocrit, 32; WBC, 19,600; platelet count, 240,000; and serum fibrinogen, 138 mg. per cent.

She was admitted to the labor room and her vital signs monitored. They were stable. Attempts to hear fetal heart tones by ultrasound and abdominal E.C.G. were unsatisfactory. The laceration of her forearm was cleaned and a suspension sling applied.

### Stillborn Female

Eight hours after admission she started into active labor. Her cervical status was as follows: cervix, five cm.; effacement, 100 per cent; station, -2. She progressed rapidly. She spontaneously ruptured her membranes and the fluid was bloody. Eight and one-half hours after admission she delivered a stillborn female, 5 pounds, 4 ounces, with the cord tightly around the neck. The placenta was delivered spontaneously. It was a circumvallate-type placenta (Figure 1). A laceration of four cm. in length was noted on the fetal surface of the placenta and it crossed through the vessels (Figures 2 and 3). At the time of delivery we were able to observe some clots around the lacerated vessels.

X-rays of the placenta were made with injection of contrast material into the vessels at the base of the umbilical cord. Figure 4 shows extravasation of dye from the lacerated artery at the point which is outlined with the needle. Figure 5 shows extravasation of dye from the lacerated vein, located one cm. below the arterial laceration which is pointed out with the needle.

Her postpartum course was satisfactory and her forearm laceration was repaired on the second postpartum day. The fetus demonstrated no gross anomalies.

Autopsy of the fetus revealed intra-alveolar and intra-bronchial hemorrhage along with bloody gastric contents. Microscopic sections of the lungs showed normal degree of maturity, marked intra-alveolar hemorrhages and alveolar spaces filled with blood (Figure 6). Also, there was acute passive congestion of the large vessels. Bronchials showed same change with sloughing of the epithelial cells. Microscopic sections of the

**Figure 1. Circumvallate-type placenta with elevated pale rim on fetal surface.**

placenta showed normal chorionic villi, but at the lacerated area there were large collections of blood between the underlying chorionic villi. In addition, the section (Figures 7, 8, 9, 10) showed a large amount of the exudate and extravasation of red blood cells with accompanying inflammatory cells at the level of laceration—which differentiates it from postpartum laceration.

In summary, the cause of death was explained on the basis of anoxia resulting from deprivation of blood supply due to placental laceration, with accompanying hemorrhages into the amniotic sac.

### Discussion

Placental damage, severe enough to compromise the fetus, can result from penetrating, or less commonly, blunt trauma.[1] An early case of placental injury resulting from blunt trauma was reported by Zimmerman in 1907.[1,13] In 1942, Van Santi described a case of maternal abdominal trauma following which fetal movements and heart tones were lost.[1,12,13] There was a rapid increase in uterine size accompanied by

**Figure 2. Laceration of placenta over fetal surface.**

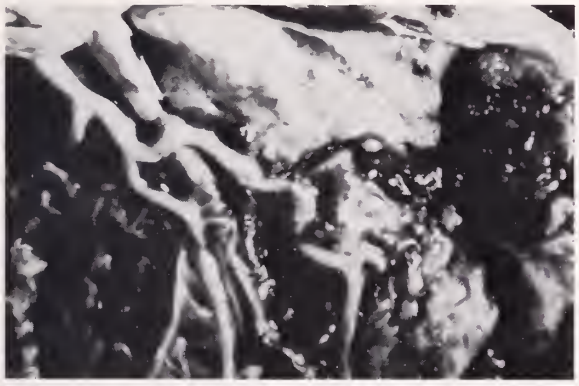

**Figure 3. Laceration of placenta over fetal surface which crosses through the vessels.**

**Figure 4. X-ray of the placenta after injection of contrast material into the artery.**

**Figure 5. X-ray of the placenta after injection of contrast material into the vein.**

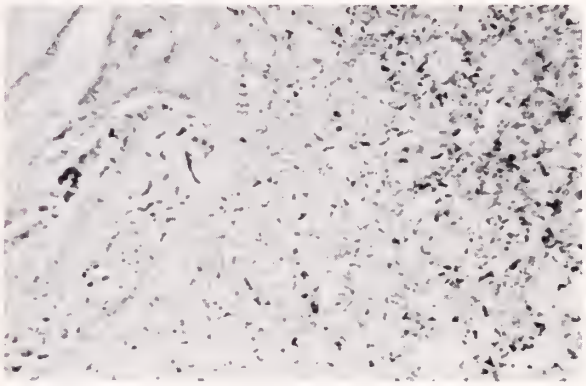

**Figure 6. Microscopic section of the lungs.**

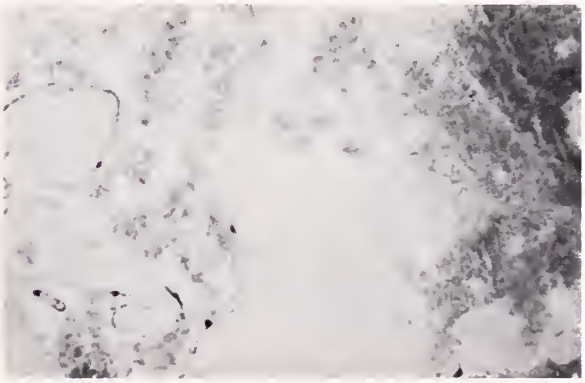

**Figure 7. Microscopic section of placenta with normal chorionic villi, large amount of exudate.**

vaginal bleding. A stillborn fetus was delivered, and the placenta revealed a clean, fresh laceration on the fetal surface.

A case was reported by Peyser and Toaff in 1967 in which the fetal surface of the placenta was torn by forces secondary to an automobile collision. The fetus died immediately of bleeding into the amniotic fluid, but was not delivered for five days.[6,13]

There was a case presented by Pepperell and Rubinstein in 1977 in which a tear of the fetal surface of the placenta occurred to a 39-week pregnant driver after a head-on collision. The fetus died immediately and was delivered after two days. The driver did not wear a seat belt.[11]

**Figure 8. Microscopic section of placenta at lacerated area.**

**Figure 9. Microscopic section of placenta at lacerated area.**

**Figure 10. Another microscopic section of placenta at lacerated area.**

The pregnant uterus, as it increases in size and comes to occupy a greater portion of the abdominal cavity, becomes increasingly susceptible to injury; unlike a solid organ, the transmitted force of a blow is distributed equally in all directions.[1] This dissipation of the force is due to the act of the amniotic fluid as a hydraulic shock absorber, which is proportionately greatest in early pregnancy to protect the fetus from blunt injury.

The resultant compression elevates intrauterine pressure and distorts the size and shape of the uterus. The placenta does not contain elastic tissue and possesses little capability to expand or contract. The uterine wall, conversely, is elastic. During the impact sequence, the unrestrained body decelerates against some part of the vehicle or, if ejected against the earth, the outside of the vehicle or other objects. The uterus flattens against that part of the abdomen that decelerates first. Then vertical waves cause rapid elongation and shortening of the long axis of the uterus, thus causing shearing and laceration of the placenta.

### Circumvallate Placenta

In our case, the circumvallate placenta was another factor in increasing the chance of the laceration. Circumvallation occurs in 2.75 per cent of all placentas. The cause of circumvallate placentation is not understood, and no maternal features in this series were identified to be more common than in other pregnancies.[14]

The problem of the advisability of using lap belts during late pregnancy remains unresolved.[16] In a study of 208 pregnant victims of severe automobile accidents by Crosby and Costiloe, 28 wore lap belts and 180 were unrestrained. Lap-belt restraint was associated with a reduction in maternal death from 7.8 to 3.6 per cent, and with increase in fetal loss from 14.4 to 16.7 per cent.[7] In the experimental findings of Crosby, King and Stoud with pregnant baboons as subjects to severe frontal decelerations, the fetal mortality was six times greater in lap-belted subjects than in those with shoulder restraint.[15] The belt reduced maternal injury[5] by preventing ejection but the greatest force was directed toward the pregnant uterus when the body of the mother jackknifed over the belt.

Traveling during pregnancy does not increase pregnancy loss unless there is traumatic injury to the mother.

**References**

1. Buchsbaum HJ: Accidental injury complicating pregnancy. *Am J Obstet Gynecol* 102:752, 1968.

2. Buchsbaum HJ: Traumatic injury in pregnancy. *Surgical Diseases in Pregnancy* 12:184, 1974.

3. Williams RD, Zollinger RM: Diagnostic and prognostic factors in abdominal trauma. *Am J Surg* 97:575, 1959.

4. Martin JD Jr, Perdue GD, Harrison WH: Abdominal visceral injury due to nonpenetrating trauma. *Arch Surg* 80:192, 1960.

5. Allen RB, Curry GJ: Abdominal trauma. *Am J Surg* 93:398, 1957.

6. Crosby WM: Trauma during pregnancy: Maternal and fetal injury. *Obstet Gynecol* 29:683, 1974.

7. Crosby WM, Costiloe JP: Safety of lap-belt restraint for pregnant victims of automobile collisions. *N Engl J Med* 284:632, 1971.

8. Diddle AW: Trauma and interruption of pregnancy. *Tex Med* 44:520, 1948.

9. Theurer DE, Kaiser IH: Traumatic fetal death without uterine injury. *Obstet Gynecol* 21:477, 1963.

10. Naeye RL: Causes of perinatal mortality in the U.S.: Collaborative perinatal project. *JAMA* 238:228, 1977.

11. Pepperell RJ, Rubinstein E, MacIsaac IA: Motorcar accidents during pregnancy. *The Med J Australia* 1:203, 1977.

12. Mayer A: Unfall in der frauenhulkunde, in seitz, des weibes, ed 2, *Wien*, 1953 urban and Schwartzenberg, Vol V, p 908.

13. Peyser MR, Toaff R: Traumatic rupture of the placenta. *Obstet Gynecol* 34:561, 1969.

14. Benirschke K: Disease of the placenta, in Gluck L: *Modern Perinatal Medicine*. Chicago Year Book, p 99, 1974.

15. Crosby WM, King AI, Stout IC: Fetal survival following impact: Improvement with shoulder harness restraint. *Am J Obstet Gynecol* 112:1101, 1972.

16. Williams JS, Lies BA, Hale HW: The automotive safety belt in saving a life may produce intra-abdominal injuries. *J Trauma* 6:303, 1966.


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Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 ½ by 11 in.) white paper. Wide margins (at least 1 ¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

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# Pregnancy Following Jejunoileal Bypass

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*The surgical efforts to control morbid obesity have acquired popularity. This has resulted in the establishment of a unique obstetrical population, and the obstetrical literature has recently witnessed a number of papers on the obstetrical performance of the post-jejunoileal bypass patient.*

*The purpose of this paper is to review such literature and add seven pregnancies occurring in four patients who underwent the surgical approach for morbid obesity.*

OBESITY is the main nutritional problem in this country. The obese patient exhibits cardiovascular problems, metabolic disorders, and pulmonary diseases, which may be associated in the female patient with problems of reproduction and altered menstrual function.

Obesity should be approached like a chronic disease. The patient needs to be treated with understanding and patience. Whatever the cause is, psychological or physiologic, obesity is the ultimate manifestation of chronic ingestion of excess calories.

Judicious medical efforts must be exercised in order to evaluate the obese patient properly and help him. The combination of exercise, psychiatric care, diet and the proper use of anorectic agents is used to achieve successful therapy. If these efforts fail to produce weight loss, then, in specially-selected patients, the surgical attempt to created an artificial malabsorption syndrome has been found successful. This decision must be arrived at by multidisciplinary approach.

In 1963, Payne and DeWind[1] described a jejunoileal bypass with retention of the ileocecal valve. They modified the procedure in 1969. This operation results in successful weight reduction, although it is not free of serious complications.

### Case Reports

*Case 1:* On 3-18-74, V. C., at age 17, underwent ileojejunal bypass, complicated later on with intussusception of the proximal part of the bypass which required surgical treatment. Forty-eight months later she became pregnant. During the pregnancy she had bouts of diarrhea treated with Lomotil®. No electrolyte imbalance was noted. At 37 weeks of gestation she had a normal spontaneous delivery of a 2,920-gram baby. Immediately after postpartum she had severe leg pain. Lab work-up revealed CA 8.5 per cent and Magnesium 1.1 per cent. She was treated with $MgSO_4$ I.V. and Calcium Gluconate I.V. Mother and baby did well.

*Case 2:* Prior to ileojejunal bypass, in 1968, B. S. had a 3,629-gram baby delivered by cesarean section. On 1-17-74, at age 26, she underwent ileojejunal bypass, complicated later on with jaundice and abnormal liver function test, treated medically. She did well. Thirteen months later she became pregnant. During her pregnancy she received vitamin B-12, iron and folic acid. Hemoglobin was 10.8 grams during the first trimester. She developed mild hypertension (140-160/80-95), but no other complications were noted. Serial sonogram revealed normal intrauterine growth of the fetus. Elective cesarean section was done at 38 weeks of gestation. She delivered a 2,807-gram baby. Postpartum was uneventful.

*Case 3:* Prior to ileojejunal bypass R. H. had two uncomplicated pregnancies and deliveries of 3,062-gram (1971) and 2,495-gram (1972) babies.

On October 14, 1974, at age 21, she underwent ileojejunal bypass. Seven months later she became pregnant. During her entire pregnancy she had bouts of diarrhea and nausea. She was admitted twice to the hospital because of diarrhea, electrolyte imbalance (Ca 9.5 mg/100, K 3.2 mEq/L, Magnesium 1.3 mg/100 ml, Serum Iron 40 ugm/100 ml, IBC 276 ugm/100 ml), dehydration and anemia. She was treated with Iberet 500®, Klorvess®, and hydration. At 35 weeks of gestation she delivered a 2,665-gram female. Mother and baby did well.

Nineteen months after ileojejunal bypass she became pregnant for the second time. This pregnancy was free of diarrhea or electrolyte imbalance. At 32 weeks gestation she had premature labor, treated with bed rest and Vasodilan®. She delivered at 34 weeks' gestation a 1,899-gram baby who developed hyaline membrane disease (HMD). The baby and mother did well.

*Case 4:* On October 13, 1975, at age 30, G. T. underwent ileojejunal bypass. She had had a previous abortion. The immediate postoperative course was complicated by pulmonary embolism. Three months after the surgery she became pregnant. She was hospitalized at 13 weeks of gestation with generalized weakness, fainting spells, edema, and anemia. Hemoglobin was 10.4 grams and hematocrit, 32. Total protein was 5.4 gm/100 ml; albumin, 2.39 gm/100 ml; Calcium, 8.9 mg/100 ml; Potassium, 3.3 mEq/L; Na, 139 mEq/L; Cl, 106mEq/L; SGOT, 205 units, LDH IU/L, alkaline phosphatase, 180 IU/L; B-12, 1162 pg/ml; and Folate, 6 mg/ml. Stools for occult blood were positive by GUAIAC method. Revision of intestinal bypass, due to malnutrition and possibility of fatty metamorphosis of the liver was considered due to the severity of her condition, but she improved with medical support, including hyperalimentation. During her entire pregnancy she continued with diarrhea and lost seven pounds. She received Proloid 3 grains/day, Slow K®, Ferrofolic®, Unicaps®, and Benedectin®.

At 29 weeks of gestation the patient spontaneously delivered a 922-gram baby who died from HMD. At this second admission the hemoglobin was 9.8 grams; Ca, 7.9 mg/100 ml; total protein, 4.4 grams/100 ml; K, 3.1 mEq/L; alkaline phosphatase, 126 IU/L; LDH, 125 IU/L; and SGOT, 71 IU/L.

On October 11, 1976, the patient underwent revision of the ileojejunal bypass because of continuous weight loss and abnormal liver function. One month later she became pregnant. She was seen at 10 weeks of gestation and was observed to have a younger and stronger appearance. During her pregnancy she was on Proloid® 3 grains/day, Ferrofolic®, and Unicaps®. This pregnancy was free of complications. She gained 50 pounds. At 36 weeks of gestation and weekly thereafter she had negative oxytocin challenge test (OCT). At 40 weeks of gestation she had a mid-forceps delivery of a 4,479-gram baby. Mother and baby did well.

Four months later she became pregnant again. During this pregnancy she had bouts of diarrhea. She delivered at term a 3,997-gram baby. Postpartum she underwent tubal sterilization.

### Discussion

The use of ileojejunal bypass in treatment of morbid obesity appears to be justified.[8] The average weight loss in our group was 77 pounds (Table 1).

Several complications after surgery have been reported: electrolyte imbalance,[10] vitamin B-12 malabsorption,[11] fatty degeneration of the liver,[12] intussusception,[13] thrombophlebitis and pulmonary embolism,[14] calcium and magnesium deficiency.[19]

Three of our patients developed serious complications following surgery: pulmonary embolism, intussusception and abnormal liver function.

Ileojejunostomy has caused fewer complications than jejunocolostomy.[3] Paine and DeWind[2] reported 10 cases of jejunocolic shunt and 70 cases with jejunoileal shunt. They "do not recommend a jejunocolic shunt." The length of the ileum anastomosed to the jejunum is very important because of its absorptive function. Neither the optimal length nor its role in the outcome of future pregnancies has been established (Table 2).

The ideal time between ileojejunal bypass and pregnancy has been reported as two years.[6] It is at this time that the metabolic alteration in the absorption of electrolytes, protein, carbohydrates, lipids and vitamins has reached a new and stable equilibrium (Table 3).

Pregnancy after this procedure has been reported by several authors,[6,5] and it would appear

**TABLE 1**

| | *Weight in Pounds* | | | |
|---|---|---|---|---|
| *Case* | *Pre-op* | *9 Mo. Post-op* | *Loss* | *% Weight Loss* |
| V. C. | 326 | 232 | 94 | 28 |
| B. S. | 350 | 270 | 80 | 22 |
| R. H. | 224 | 172 | 52 | 23 |
| G. T. | 287 | 205 | 82 | 28 |

**TABLE 2**

| | *Measurement of Bypass* | |
|---|---|---|
| *Case* | *Jejunum (in.)* | *Ileum (in.)* |
| V. C. | 12 | 12 |
| B. S. | 15 | 5 |
| R. H. | 14 | 10 |
| G. T. | 12 | 6 |

**TABLE 3**

| *Case* | *Time of Surgery* | *Time of Conception* | *Time (Months)* |
|---|---|---|---|
| V. C. | March, 1974 | August, 1977 | >24 Months |
| B. S. | January, 1974 | February, 1975 | 13 Months |
| R. H. | October, 1974 | May, 1975 | 7 Months |
| G. T. | October, 1975 | January, 1976 | 3 Months |

that there will be an increased number of such cases in coming years. This seems predictable because of the popularization and better understanding and management of intestinal shunt surgery. Pregnancy is not contraindicated after ileojejunal bypass surgery as long as the physician is aware of the likelihood of nutritional deficiencies that might be associated with pregnancy.

### Complications

Diarrhea appears to be one of the most common complications. Immediately after ileojejunal bypass, diarrhea occurs in 100 per cent of the patients, and at the end of one year it consists of two to three soft stools daily.[19] It seems probable that during pregnancy the severity of the diarrhea is directly related to the elapsed period of time since the ileojejunal bypass surgery.

Hepatic changes after ileojejunal bypass are the most serious complications. Treatment with hyperalimentation has been proposed by Ames,[20] who suggests that reversal of the bypass is indicated if there is not improvement in the seriously-impaired hepatic function.

One of the patients, G. T., reported in this series, had alterations of hepatic test values during pregnancy. She was treated medically and improved, but after delivery she underwent revision of the ileojejunal bypass because of continuous weight loss.

Potassium is absorbed in the jejunum by simple diffusion and in the ileum by active transport. Hypocalcemia was found in one of our patients. She was treated with an oral potassium preparation with good results.

Calcium deficiency has been reported to be usually associated with magnesium deficiency.[19] This deficiency was present in one of our patients. She complained of severe leg cramps a few hours after delivery. Serum magnesium was 1.1 per cent. She was treated with intravenous magnesium sulfate with prompt relief of the leg cramps and normalization of the serum magnesemia.

Pregnancy-induced hypertension in the bypass patient has been reported.[6,7,18] Ingardia[18] reported four of 20 pregnancies with mild-to-moderate hypertension. One of our patients developed mild hypertension during her pregnancy.

Other complications that have been reported during pregnancy are hypoproteinemia, vitamin K deficiency,[7] malnutrition,[5] and anemia secondary to iron deficiency.[16]

Vitamin B-12 deficiency after ileojejunal bypass has been reported in 75 per cent of the patients. It has been recommended that every patient should receive vitamin B-12 monthly;[21] nonetheless, there is no report of megaloblastic anemia during pregnancy following ileojejunal bypass (Table 4).

The weights of the babies born following ileojejunal bypass have been reported repeatedly as less than those born before the procedure (Table 5). Birth weights have been reported below average by Savel,[9] reviewing several series. The five babies delivered after ileojejunal bypass surgery were below 3,000 grams. One of the patients who underwent revision of the ileojejunal bypass delivered a 4,479-gram baby afterwards.

All of our patients had vaginal deliveries, except for one repeat cesarean section. No complications were noted during labor and delivery. There is one report of increased fetal abnormality.[9] Only one out of five deliveries in this series was 38 weeks of gestation or more, and two out of five weighed less than 2,500 grams (Table 6). In the summary of 85 cases published by Savel, most were delivered at term.

A direct relationship between infant weight and maternal serum albumin has been reported.[22] Following ileojejunal bypass (surgery) there is a lower serum albumin level. It has been postulated that the hypoalbuminemia is a cause for S.G.A. babies. The total weight gain during

**TABLE 4**
**Complications During Pregnancy**

| *Case* | *Complications* |
|---|---|
| V. C. | Hypocalcemia; Hypomagnesemia; Diarrhea |
| B. S. | Hypertension; Anemia |
| R. H. | Diarrhea; Hypopotassemia; Anemia; Hypomagnesemia; Premature Labor |
| R. H. | Premature Labor |
| G. T. | Diarrhea; Electrolyte Imbalance; Hypoalbuminemia; Anemia; Abnormal Liver Function |
| G. T. | None |
| G. T. | Diarrhea |

**TABLE 5**
**Weight of Infants (GMS)**

| | *Pregnancies* | | | | | |
|---|---|---|---|---|---|---|
| *Case* | *Before Bypass* | | *After Bypass* | | *Revised Bypass* | |
| | 1st | 2nd | 1st | 2nd | 1st | 2nd |
| V. C. | --- | --- | 2920 | --- | --- | --- |
| B. S. | 3629 | --- | 2807 | --- | --- | --- |
| R. H. | 3062 | 2495 | 2665 | 1899 | --- | --- |
| G. T. | AB. | --- | 992 | --- | 4479 | 3997 |

pregnancy in this series was below the 24-pound average weight gain reported by Chesley (1944) (Table 7). It appears that among several factors that contribute to the S.G.A. baby, lack of weight gain during pregnancy could be one.

In summary, although pregnancy after ileo-jejunal bypass appears to be safe, the patient should be monitored carefully during her prenatal course and neonatal period.

**TABLE 6**

| *Case* | *Gest. Age* | *Type Del.* | *Apgar* | *Weight Grams* |
|---|---|---|---|---|
| V. C. | 37 | NSD | 8-9 | 2920 |
| B. S. | 38 | REP. C/S | 7-8 | 2607 |
| R. H. | 35 | LFD | 9-9 | 2665 |
| R. H. | 34 | LFD | 6-8 | 1899 |
| G. T. | 29 | NSD | 5-5 | 992 |
| G. T. | 40 | LFD | 9-10 | 4479 |
| G. T. | 40 | LFD | 8-10 | 3997 |

**TABLE 7**

| | *Weight in Pounds* | | | | |
|---|---|---|---|---|---|
| *Case* | *Weight Before Bypass* | *1st. Tri.* | *2nd. Tri.* | *Del.* | *Gain* |
| V. C. | 326 | 171 | 180 | 190 | 19 |
| B. S. | 350 | 176 | 182 | 186 | 10 |
| R. H. | 224 | 178 | 178 | 183 | 5 |
| R. H. | | 160 | 165 | 169 | 9 |
| G. T. | 287 | 212 | 205 | 205 | -7 |
| G. T.° | | 188 | 218 | 238 | 50 |
| G. T.° | | 249 | 258 | 265 | 16 |

°Revised Bypass

**References**


1. Payne JH, De Wind LT, Commons RR: Metabolic observations in patients with jejunocolic shunts. *Am J Surg* 106:273, 1963.

2. Payne JH, De Wind LT: Surgical treatment of obesity. *Am J Surg* 118:141, 1969.

3. Barron J, Frame B, Bozalis JR: A shunt operation for obesity. *Dis Colon Rectum* 12:115, 1969.

4. McCarthy PJ: Pregnancy following jejuno-ileal bypass. *Obstet Gynecol* 43:455, 1974.

5. Everett RB, Crosby W, Welch JD, Thompson JB: Pregnancy after jejuno-ileal bypass for obesity. *Surg Gynecol Obstet* 139:215, 1974.

6. Ayers M: Obstetric and gynecology effects of the ileal shunt. *Ohio State Med J* Nov, 1973, p 834.

7. Wills CE: Obstetrical delivery after jejuno-ileostomy for obesity. *J Med Assoc Ga* 60:39, 1971.

8. Scott HW Jr, Law DH, Sandstead HH *et al.*: Jejunal shunt in surgical treatment of morbid obesity. *Ann Surg* 171:770, 1970.

9. Savel LE, Simon SR, Maxon WS: Pregnancy after jejuno-ileal bypass: A review and report of one case. *Obstet Gynecol* 52 (Suppl):58S-60S, July, 1978.

10. Lewis LA, Turnbull RB, Page ILHL: Effects of jejuno-colic shunt on obesity, serum lipoproteins, lipids, and electrolytes. *Arch Int Med* 117:4-15, 1966.

11. Buchwald H: Vitamin B-12 absorption deficiency following bypass of ileum. *Am J Dig Dis* 9:755-759, 1964.

12. Maxwell JG, Richards RC *et al.*: Fatty degeneration of the liver after intestinal bypass for obesity. *Am J Surg* 116:648-652, 1968.

13. Kauffman HJ, Weldon HW: Intussusception, a late complication of small bowel bypass for obesity. *JAMA* 202:1147-1148, 1967.

14. Phillips RB: Small intestinal bypass for the treatment of morbid obesity. *Surg, Obstet, Gynecol* 146:455-456, 1968.

15. Porter, Personal communication to M. A. Ayers (6).

16. Salmon PA: Discussion, Ob-Gyn Collected Letters, Series XVII, p 133, Aug 15, 1976.

17. Taylor JL, O'Leary JP: Pregnancy following jejunoileal bypass, effects on fetal outcome. *Obstet Gynecol* 48:426, 1976.

18. Ingardia CJ, Fischer JR: Pregnancy after jejuno-ileal bypass and the SGA infant. *Obstet Gynecol* 52:215-218, 1978.

19. Starkloff BG, Donovan JF, Ramach KR, Wolfe BM: Metabolic intestinal surgery: Its complications and management. *Arch Surg* 110:652, 1975.

20. Ames FC, Copeland EM, Leeb DC: Liver dysfunction following small bowel bypass for obesity: Nonoperative treatment of fatty metamorphosis with parental hyperalimentation. *JAMA* 235:1249, 1976.

21. Juhl E, Bruusgaard A, Hippe E, *et al.*: Vitamin B-12 depletion in obese patients treated with jejunoileal shunt. *Scand J Gastroenterol* 9:543, 1974.

22. Stein H: Maternal protein depletion and small-for-gestational age babies. *Arch Dis Child* 50:146-148, 1975.

# Myelofibrosis-Polycythemia Syndrome On Congenital Hypoplastic Anemia: A Case Report

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*This is an unusual case report of a young man who died at the age of 19 of hepatic failure. The diagnosis of congenital hypoplastic anemia was made at the age of three months. He was transfused a total of 624 times and this was calibrated into 426 complete transfusions. The diagnosis of hypersplenism was made 15 years later and splenectomy was required to correct his leukopenia and thrombocytopenia. His transfusion requirements were thereafter decreased. Histologic examinations of all tissues removed showed extensive hemosiderosis and hepatic cirrhosis. The white blood cell count and platelet count returned to normal.*

*Other therapies included cortico-steroid, anabolic hormone, and pyridoxine. Transfusions were not required after age 17.*

*At age 18, his bone marrow showed myelosclerosis and his hemoglobin increased to 18.9 gms per cent. He was given deferoxamine therapy. Two phlebotomies were performed. He died of hepatic failure.*

THE purpose of this paper is to present the history of a young man who died at the age of 19. The diagnosis of congenital hypoplastic anemia was made at the age of three months. He received a total of 426 calibrated complete transfusions during his lifetime, developed hypersplenism necessitating splenectomy, and later on developed a myelofibrosis-polycythemia syndrome, requiring phlebotomies. Various other therapies included cortico-steroid, anabolic hormone, pyridoxine and deferoxamine.

### Case Report

At the age of three months, normochromic, normocytic anemia was noted, and his bone marrow showed the absence of nucleated red cells. Transfusions were started and were required every few weeks.

In 1970, it was noted that his spleen was enlarged 14.5 cm. below the left costal margin and the liver was enlarged 11 cm. below the right costal margin. The red cells showed 2+ anisocytosis and poikilocytosis, and several spherocytes were seen. The platelet count was 25,000/cubic millimeter, and repeated total white blood cell counts were below 1,000/cubic millimeter. A sample of the sternal bone marrow showed myeloid hyperplasia, erythroid hypoplasia, and eosinophilia. The M. E. ratio was 9.3 to 1.0. Adequate numbers of megakaryocytes were seen, but few were producing platelets.

The diagnosis of hypersplenism was made and splenectomy performed. The spleen, accessory spleen, hilar lymph nodes, and liver showed extensive hemosiderosis. The liver showed cirrhosis. His postoperative course was good and his white blood cell counts and platelet counts returned to normal; transfusion requirements were decreased to about three units of packed cells every six weeks. At that time, he had classic skin changes of hemosiderosis and was diminutive in stature. His cortico-steroid therapy was reduced and he was started on pyridoxine, 100 mg. b.i.d., and stanozolol, four mg. daily, the former to facilitate iron incorporation into hemoglobin and the latter to stimulate erythropoiesis.

### Liver Function Aberrations

At the age of 17, he developed distinct aberrations of liver function. It was noted that he had a hypoplastic aorta on chest x-ray. The diagnosis of hypothyroidism was made and thyroid therapy was started. During that year he had two bouts of pneumonia, successfully treated. The peripheral blood at that time showed a myeloid shift and a few nucleated red cells. His platelets remained adequate on smear. He was transfused for the last time in November, 1973.

He maintained a normal or increased hemoglobin for the rest of his life, but the peripheral blood showed progressive myeloid left shift and a moderate fall in platelets. In December, 1973, a good bone marrow biopsy was obtained. The general cellularity was good, but a few particles were fibrotic and showed numerous platelet clumps and megakaryocytic nuclei. Iron storage was excessive with the presence of numerous ringed sideroblasts. The M.E. ratio at that time was 1.8 to 1.0. He was started on deferoxamine, one gram I.M. weekly, and for several hours after each injection, the urine was dark. The serum iron was 343 mcg per cent and the total iron binding capacity was 495 mcg per cent. In April, 1974, a 450-cc. phlebotomy was performed as his hemoglobin had risen to 18.9 gms per cent. One other phlebotomy was performed. From then un-

til he died in June, 1974, the hemoglobin ranged between 14.7 and 16.4 gms per cent. He had no side effects from this therapy. He died in a nearby community hospital of hepatic failure shortly after having been seen at my office. An autopsy, unfortunately, was not authorized. During his short life span he was transfused 624 times, and this was calibrated into 426 complete transfusions.

### Discussion

The reader is directed toward the treatise on congenital hypoplastic anemia in a 1974 edition of *Hematology of Infancy and Childhood* by Nathan and Oski.[1] A full bibliography is included.

I write this article not for its singularity or rarity, but to present to interested readers the dastardly end results of long-term transfusion therapy in this and other hematologic disorders. In spite of this, this young man had a good quality of life and enjoyed working on the farm, sports, and driving his car. He did finish high school and participated in high school athletics. His hypersplenism did respond dramatically to splenectomy and he did have a gradual increase in marrow nucleated red cells over the years.

The hemosiderosis-induced myelofibrosis may well have responded to cortico-steroid and anabolic hormone therapy. I am unsure as to the etiology of his erythrocytosis. Blood volume studies and erythro-kinetic studies were not performed. This could represent either spontaneous remission, response to pyridoxine, or response to anabolic hormone therapy. His response to deferoxamine was good clinically, but time did not permit a long-term study of iron loss as compared with iron storage. He had no apparent pulmonary or cardiac abnormality.

Anabolic hormone therapy probably should have been started early on in his disease, and long-term cortico-steroid should have been used daily. Deferoxamine and pyridoxine probably should have been given earlier at regular intervals.

The combination of cortico-steroid, anabolic hormone, pyridoxine, transfusions, and regular deferoxamine therapy should be entertained as treatment in similar cases in an effort to prevent terminal hemosiderotic cirrhosis, which inevitably occurs and is one of the major causes of death.

### Reference

1. Nathan DG, Oski FA: *Hematology of Infancy and Childhood*, Philadelphia, Sanders, 1974.

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*Not to be covetous is money in your purse; not to be eager to buy is income.*

—Cicero

# Not All Sadness Can Be Treated With Antidepressants

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*Not every dysphoric patient should receive antidepressants; therefore, the decision to use tricyclic antidepressants needs to be weighed carefully. This article concerns those patients who should not be given tricyclic antidepressants routinely without consideration.*

THE use of antidepressant medications has been an excellent and rewarding adjunct to the treatment of severe depression. Great strides have been made in understanding the biochemistry and medical management of affective illness since the 1950s. The treatment for depression prior to the advent of antidepressant medications consisted of electroconvulsive treatment, stimulants such as amphetamines for psychomotor retardation, and barbiturates for agitation.

The original antidepressant medications were monoamine oxidase inhibitors. A few years later, tricyclic antidepressant compounds were introduced. This group of compounds is now frequently prescribed by both psychiatric and nonpsychiatric physicians. These are now being considered useful in many medical situations such as migraines, chronic pain syndromes, etc. In the United States, the number of prescriptions for antidepressants continues to grow annually. As with any of the psychoactive drugs, they should be used appropriately. It is important to know when to withhold tricyclic antidepressant therapy as it is to know when to use it.

### Personality Disorders

Tricyclic antidepressants are extremely potent drugs with the therapeutic window not significantly removed from potentially life-threatening complications from an overdose. The ingestion of a relatively small number of tablets can produce a lethal overdose. Thus, great care must be taken in the selection of patients who receive such prescriptions.

Many suicide attempts are impulsive. The suicidal patient frequently has much hostility directed toward another person who has not met the needs of the patient. These patients will not always give a very strong history for biologic depression such as appetite disturbance, decreased libido, sleep disturbance, diurnal variation in mood, constipation and crying episodes—nor do they demonstrate psychomotor retardation or agitation. They will frequently be dysphoric, but a detailed past social history will often reveal a long-term personality style which has contributed to this dysphoria. Many physicians mistakenly equate dysphoria with biologic depression. Dysphoria is certainly present in depression, but this sadness frequently has a psychological, rather than a biological, base. This does not preclude the fact that people with personality disorders can become biologically depressed and thereby require medical treatment. There are, however, innumerable patients with chronic personality and character disorders who have received tricyclic antidepressant therapy without real justification. These patients frequently and impulsively take pills in a suicide attempt or gesture.

### The Grieving Patient

Many patients suffer an appropriate alteration in mood and affect secondary to a real loss. This may reflect the loss of a loved one, loss of ability to perform duties secondary to chronic medical illness, or tragic disruption of physiological functions during either an acute or chronic disability occasioned by surgical procedures, accidents, etc. These patients are indeed dysphoric and may ultimately develop severe biologic depression. Unfortunately, many physicians choose to begin antidepressant therapy too soon following the acute loss. This may, on occasion, be justified in some patients, but as a rule it robs the patient of the psychological repair that must occur for a grief reaction.

### The Organic Patient

Occasionally, tricyclic antidepressants are prescribed for patients who have an organic brain syndrome rather than a true depression. These patients can become withdrawn, apathetic and exhibit psychomotor retardation. The physician fails to realize how closely dementias can resemble depression, and does not make use of a detailed mental status examination or a past medical history which might reveal a rather marked cognitive impairment.

It should be kept in mind that in the elderly a reversed process may occur with severe depression presenting as a dementia, i.e., pseudodementia. The subtleties differentiating an organic dementia from a functional dementia (pseudodementia) are sometimes quite difficult to appreciate. A thorough neurological and medical evaluation is needed to make such a differentiation. If psychological testing cannot distinguish these entities, a trial of antidepressants may be indicated. The patient must be observed carefully because the severity of some organic brain syndromes can be exacerbated by tricyclic antidepressant therapy. Antidepressants are obviously a poor choice in a true organic brain syndrome which is masquerading as a depression.

### The Unwilling Depressed Patient

Physicians sometimes make decisions regarding therapy without fully explaining their reasoning and desired results to their patients. Such explanations are particularly important to patients with psychiatric illnesses. A prescription for a psychoactive drug is sometimes offered without probing the patient's thoughts about taking such a drug. Patients have realistic worries and fantasies about the benefits and harmful effects of psychoactive drugs. Even if the drug of choice is a tricyclic antidepressant for a depressed, non-suicidal patient, little is accomplished by a physician's dogmatic efforts to force an essentially unwanted treatment upon a patient. Many patients (especially those with repeated bouts of reactive depression) have "weathered the storm" in the past and feel a much stronger need for supportive measures and psychotherapy, and prefer to rely on medications only as a last resort.

Physicians should not prescribe antidepressants without discussing with the patient the anticipated goals, possible side effects and the patient's attitude toward treatment. In many of these instances, the need for tricyclic antidepressants is a borderline decision.

### The Younger Patient

There is little doubt that the most severe and refractory biologic depressions occur in middle-aged and elderly patients. The adolescent and young adult patient can, however, have severe endogenous depression, especially if the family history suggests affective disease. The majority of younger patients have depressive episodes which center around concerns about future, job, career, and interpersonal relationships. There is obviously no medication which can change these identity issues, and psychotherapy is certainly indicated. Younger patients demonstrate rapid deviations in mood which reflect frequent changes from the baseline. One should always keep in mind, just as noted in those patients who have chronic personality disorders, that an appreciation of the highest previous level of functioning is a very important consideration before a decision to prescribe medication for the younger depressed patient is reached.

Another consideration to keep in mind is that schizophrenia also is an illness which frequently presents itself in the younger patient. The younger patient with a thought disorder will frequently present with dysphoria. Many of these patients do much better on major tranquilizers rather than on tricyclic antidepressants. As a general rule, the major tranquilizers are much safer drugs to prescribe insofar as overdose attempts are concerned.

### Summary

The important consideration in prescribing any psychotropic medication is close follow-up. Tricyclic antidepressants are excellent medications for appropriate illnesses and for selected patients. The greatest danger occurs when both patient and physician equate sadness with a need for antidepressant medications. The tricyclic antidepressants are not a panacea and can be detrimental or even dangerous in some instances. The prescribing of tricyclics merits serious consideration by the physician and a full discussion of this therapy with the patient.

### References

1. Lion JR: Affective Disorders, in *The Art of Medicating Psychiatric Patients*. Baltimore, The Williams & Wilkins Co, 1978, pp 55-102.

2. Baldessarini RJ: Antidepressant Agents, in *Chemotherapy in Psychiatry*, Cambridge, Mass., The Harvard University Press, 1977, pp 75-125.

*A message from . . .*

*The President*

## CRAZY FEELINGS

WANT to know how it feels to be crazy? It's scary and seems dangerous, like a nightmare where everything keeps tilting and sliding away and you just can't get your balance. Try thinking about this radio ad, but not too hard—"Hurry on in and buy your new mobile home while the price is still lower than it will be."

I heard it on the way to the hospital one morning. I almost had to turn around and go back to bed. There is something about a statement like that that stays just beyond your grasp. The harder you try to understand, the more disoriented you become.

I get similar feelings whenever I think about the West Virginia Medicaid Program and the MMIS (Medicaid Management Information System), a new computer operation. Briefly, MMIS is a new effort on the part of Welfare to satisfy a longstanding complaint of slow payment by physicians and anyone else doing business with Medicaid.

Now, don't you think that would be satisfying to everyone? But, no! What do we hear from those wretched and ungrateful providers? A renewed chorus of complaints, grumbles and criticisms!

But why? Well, as it turns out, the dollar cost of translating diagnoses and procedures into numerical codes and filling out the new computerized forms is enough to throw the whole transaction into the red. It would be cheaper, it seems, to see the patient for nothing and to send no bill.

The economic foolishness of continuing to see Welfare patients had been occurring with increasing frequency to increasing numbers of West Virginia physicians long before MMIS tipped the scales for a flood of now-angry physicians.

In the editorial section of this issue, the Association makes certain observations and suggests a series of remedies. Medicaid is in serious difficulty in West Virginia. I hope the problems can be worked out.

In the meantime, I trust that West Virginia physicians will continue to meet our personal obligations to the poor and sick: and that we will carry on the age-old tradition of the medical profession to provide care to others in need, regardless of their ability to pay.

Stephen D. Ward, M.D.

STEPHEN D. WARD, M. D., *President*

The West Virginia Medical Journal

# Editorials

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**MEDICAID PROBLEMS**

When we point out that West Virginia is ranked 46th among the states in average Medicaid fees paid to providers, and that the Medicaid program is in some trouble, some large mouth with a small brain attached is sure to say we should be grateful that West Virginia is not No. 50. That peerless critic will have missed the whole point.

Most doctors can manage to make ends meet without any Medicaid patients. The real difficulty is that an increasing number of them are doing exactly that.

"Oh yes," one might conclude, "the real problem is that the poor are being left to suffer and die when they get sick." And one would be mistaken.

The real problem is created by the welfare recipient's second choice when his doctor elects to limit or eliminate the Medicaid part of his practice. That patient then almost invariably begins attending the outpatient department or emergency room of the nearest hospital for his medical care.

In West Virginia, Medicaid pays a doctor seven dollars for an office visit. Hopefully, some definite steps under way at this writing will result in an increase in this figure for the first time in some five years. But Welfare pays the hospital outpatient department or emergency room $12 for the same service, plus, at least the seven-dollar physician's fee for care he or she might provide there. The situation is even worse in some other states. In New York, Medicaid pays the doctor six dollars and the hospital $55 for the same service.

Hospital spokesmen in West Virginia inform us that the Medicaid disbursements received for outpatient services do not come close to meeting present-day costs.

Every doctor has overhead expenses in the conduct of his practice. A popular figure to quote is "what it costs every time a patient walks through my door." This figure is arrived at by summing up rent, utilities, taxes, salaries, equipment, supplies, etc., and dividing that sum by the number of patient visits. There is no reliable figure in that category to quote for West Virginia doctors. Depending on location, type of practice and many other factors, that cost per patient for most doctors probably is in the range of six to eight dollars and has been going inexorably upward.

It would be a little misleading to suggest that a West Virginia doctor with expenses of eight dollars per patient visit is paying one dollar for the privilege of caring for each Welfare patient, but it is perfectly clear that if his practice is made up in any substantial measure of Welfare patients, he soon will be on Welfare himself.

It is because of these stark economic facts that many West Virginia physicians have stopped seeing completely, or limited the number of, welfare Medicaid patients. Under the present arrangements, each time a physician makes either choice, Welfare costs go up. We have no idea what percentage of Medicaid patients are currently being seen in hospital emergency rooms and outpatient departments. We are certain, however, that the percentage is rising.

It also seems crystal clear that some reasonable upward adjustment in the fee paid physicians—something which would enable those physicians to continue to see Welfare patients—could work to the significant cost-wise advantage of the Welfare Agency.

For some years now, we have been interested spectators at the annual scuffle between legislative finance committees and the Department of Welfare as they contest deficits run up by the Department in the Medical Services Program. This year, with an obvious shortage of funds from the beginning for this fiscal year, Commissioner Ginsberg first talked about needing a $9.2-million supplemental appropriation in state funds. The Governor's Executive Budget proposed an $8-million supplemental appropriation for the Medical Services Program, and a $45-million appropriation for next year.

After 60 days of controversy, emotion, and melodrama, the Legislature provided a $7.5 million supplemental appropriation, and cut the $45 million for next year to $40 million. At the same time, it stipulated in the budget act that none of the $40 million for the coming fiscal year could be used to fund the medically indigent program —that program providing medical services to some 16,000 people not eligible for public assistance, but in the needy category.

To avoid breaking the law by having to carry the medically indigent invoices over into the new fiscal year beginning July 1, the Department notified recipients of the service that they would lose their medical cards May 31. The Department also noted a projected saving of about $3.5 million in federal and state money for June, with something over one million dollars of that in state funds.

We were pleased at the recent announcement that a between-session legislative study committee intends to take up Welfare medical care programs in its forum, hopefully in a dispassionate atmosphere that will promote an objective study of the entire problem.

Serious difficulties exist not only in funding, but also in implementing the various Welfare medical care programs. Perhaps in these interim sessions the legislators can learn just what the state can afford in the way of Welfare medical care. And perhaps Welfare can be induced to apply a little common sense and pragmatism in its administration of the programs deemed affordable.

We have several suggestions for consideration in ongoing program development and operations, assuming that there are no statutory or regulatory bars against them:

1. In the interest of holding down over-utilization and avoiding abuse, we suggest CO-PAYMENTS FOR MEDICAID SERVICES. We understand there are countless patients about the state who spend significant parts of their waking hours visiting doctors' offices and hospital emergency rooms.
2. To encourage family responsibility for ill or aging members, we suggest FAMILY CONTRIBUTIONS TOWARD THE COST OF NURSING HOME CARE FOR MEDICAID RECIPIENTS.
3. To maximize the use of available funds, we suggest Welfare should HALT ELIGIBILITY FOR ABUSE. And we further recommend quick PROSECUTION FOR FRAUD by any provider.
4. For long-range planning and to facilitate cutbacks or additions to the overall program, we recommend that A SYSTEM OF PRIORITIES BE ESTABLISHED among all the categories of care.
5. We finally recommend that every effort be made to ASSURE THAT PROFESSIONAL SERVICES ARE PROVIDED IN THE MOST ECONOMICAL SETTING. To accomplish this, it is quite clear that the cost disparity between care provided in a physician's office and that same care provided in a hospital setting must be bridged.

We assure all parties of our continued interest in the problems and in any proposed solution to the problems. We likewise assure all parties of our assistance in studying the problems.

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**DARK CLOUDS**

Some dark clouds have arisen on the horizon of government and other support for medical education. Some congressmen are out to eliminate capitation grants for medical schools, for example.

Effective April 18—and reflecting new Carter Administration credit restrictions—the American Medical Association - Education and Research Foundation (AMA-ERF) had to suspend its Guaranteed Student Loan Program.

The credit restrictions require a 15-per cent, non-interest bearing reserve deposit on all non-secured personal loans. Since its 1962 inception, AMA-ERF has guaranteed 75,000 loans valued at $95 million. Current loans outstanding ran $45 million in late April.

Because it did not appear the President was trying to shoot down student loan programs as such (since the reserve requirement did not cover federally-guaranteed such loans) AMA-ERF immediately sought a specific exemption from the reserve provision.

"The Government should be on the lookout for every opportunity to build on what is available in the private sector. The AMA-ERF and its major participating banks are not prepared to provide loan funds burdened by this additional expense," AMA Executive Vice President James H. Sammons, M. D., said.

Whatever the outcome of this dilemma, and despite some encouraging action by the House Subcommittee on Health and Environment in marking up a reauthorization of the Health Manpower Program, the AMA and others face a real challenge in efforts to assure medical students continued access to adequate resources.

The House Subcommittee reflected some of the AMA's concerns in the bill it reported to the Committee on Interstate and Foreign Commerce. Capitation grants would be continued through fiscal 1983—but on the darker side, authorization for them would drop from $34 million in fiscal 1981 to $12 million two years later on a phase-out schedule.

Back to the plus side, the National Health Service Corps would be continued with some modification, as would be the Health Education Assistance Loan Program providing student loans, and an Exceptional Financial Need scholarship program.

Another health professional student loan program likewise would be continued, but with a funding authorization cut of about 28 per cent. Special project grants would be continued, with special emphasis on those for "general internal medicine and general pediatrics;" family medicine, and for establishment of departments of family practice.

On the West Virginia level, the State Medical Association continues to award each year four-year scholarships, worth $1,500 a year, to four students entering the first-year medical school classes at West Virginia University and Marshall University.

In recent days, in such circles as the WVU Liaison Committee, questions have been raised as to whether the Association might provide more help to more students by converting its scholarship program—now moving toward an annual cost of $24,000—to a loan program.

Long-time members of the Association recalled that this suggestion had arisen—and been considered several years ago. There are some that think now might be the time to give the idea further thought.

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**QUALITY FIRST**

Recent, additional testimony before a U. S. Senate Finance Subcommittee in the general area of catastrophic national health insurance brought from the American Medical Association a re-affirmation of basic legislative principles and philosophies which should be understood by all physicians.

The Finance Committee's Subcommittee on Health has been dealing with a so-called "pro-competition" approach to national health insurance. Such legislation would be designed to lower the national expenditure for health care by assuring options of coverage to employees under employer-adopted health plans.

One proposal calls for a sharp curtailment in the current tax deduction for health insurance premiums, and for individual medical expense costs, in an effort to force employers and individuals to seek lower cost plans, including health maintenance organizations.

Lowell Steen, M. D., the Chairman of the AMA's Board of Trustees and a Hammond, Indiana, internist, told the subcommittee that the AMA supports the principle of increased competition through multiple insurance options for employees.

He cautioned, however, that "any legislation embodying such principles must also carry sufficient safeguards to protect the purchaser . . . " He added that "we must never let quality be sacrificed to cost considerations."

The key issue about which any reasonable health planning, at any level, must be built thus has once more been clearly identified. To paraphrase a famous U. S. military leader of the past century, Medicine needs to fight for this principle even if it takes from now to eternity.

Doctor Steen repeated another now-familiar theme strongly supported by the AMA. Changes should be made in the private insurance system that could go a long way toward closing current gaps in coverage, he said.

He said such changes should include minimum standards of adequate benefits, with appropriate deductibles and co-insurance; a simple system of uniform benefits provided by federal, state and local governments for those unable to provide for their own medical care; and provisions for private catastrophic coverage.

"A nationwide program could be instituted by . . . private industry (and Government if necessary for re-insurance) to make available catastrophic coverage to protect against the impact of a costly illness that could be economically devastating. We call upon the subcommittee to consider these points when reviewing any health insurance proposal," Doctor Steen advised.

Doctor Steen also reminded the subcommittee that a concept of increased competition through limitation on the tax exclusion by employees with regard to employer-paid premium, and a system of cash rebates for low-cost plan selection, was contained in a National Commission on the Cost of Medical Care recommendation—one that the AMA approved.

"However, we have reservations about a program that might encourage the individual to acquire less coverage than is desirable," Doctor Steen stressed.

# GENERAL NEWS

## Learning Problems, Food-Drug Effects Meeting Topics

Learning disabilities and the roles of food and drugs in diseases will be the subjects of two papers during the 113th Annual Meeting of the State Medical Association August 20-23 at the Greenbrier in White Sulphur Springs.

Donald S. Robinson, M. D.

William B. Svoboda, M. D.

"Food- and Drug-Induced Diseases" will be the topic of a presentation by Dr. Donald S. Robinson, M. D., of Huntington during the first general session on Thursday morning, August 21, it was announced by the Program Committee.

It also was announced that Dr. William B. Svoboda of Morgantown will speak on "Learning Disabilities Associated with Medical Problems" during the second general session Friday morning.

Doctor Robinson is Chairman of the Department of Pharmacology, and Professor of Pharmacology and Medicine at Marshall University School of Medicine, while Doctor Svoboda is Associate Professor, Pediatrics and Neurology, at West Virginia University School of Medicine.

Convention activities will get under way with a 2 P. M. meeting of the Association's Executive Committee on Tuesday, August 19; the usual pre-convention meeting of the Council at 9:30 A. M. on Wednesday, and the first session of the House of Delegates at 3 o'clock that afternoon.

Dr. Robert B. Hunter, AMA President Elect, as announced previously, will address the opening House session Wednesday. He will be installed as AMA President in July.

Delivering the keynote Thomas L. Harris Address during 9 A. M. opening exercises on Thursday, also as announced previously, will be Dr. William R. Barclay, Editor of The Journal of the American Medical Association (JAMA). The first general session will be held immediately following the opening exercises.

Doctor Robinson also is a member of the medical staff, Departments of Medicine and Pharmacology, at the Veterans Administration Medical Center in Huntington.

He joined the MU and VA staffs in 1978 after having served as Professor of Medicine and Pharmacology at the University of Vermont College of Medicine in Burlington.

### FDA Consultant

A Diplomate of the American Board of Internal Medicine, Doctor Robinson is a Consultant for the U. S. Food and Drug Administration (since 1973), and is a member of the FDA's Psychopharmacology Advisory Committee.

He is a native of Pittsfield, Massachusetts, was graduated from Rennsselaer Polytechnic Institute in Troy, New York, and received his M. D. Degree in 1959 from the University of Pennsylvania School of Medicine.

Doctor Robinson is the author or co-author of 60 articles and 38 papers.

Doctor Svoboda, certified in pediatrics in 1968, has conducted extensive studies of epilepsy and learning disabilities. A Past President of the Mountain State Epilepsy League (West Virginia Chapter of the Epilepsy Foundation of America), he was appointed to the Section on Institutionalized Epileptic Patients, Task Force on Institutional Epileptics of the Federal Epilepsy Commission, in 1977. The Section report was included in the Plan for Nationwide Action on Epilepsy, Volume II, published in 1978.

Doctor Svoboda, in 1977, completed and distributed to West Virginia State mental health and institutional personnel and pediatric and neurological house staff a two-volume manual and audio-visual slide cassette programs on epilepsy.

### Author of Book

He is the author of the book, *Learning About Epilepsy*, published in 1979, and the pamphlet, "Specific Learning Disabilities in Epileptic Children," as part of the School Alert Packet, 1979-80, distributed by the Epilepsy Foundation of America.

A native of Omaha, Nebraska, Doctor Svoboda was designated by the Epilepsy Foundation of America as State Coordinator of the National Plan of Action on Epilepsy in 1979.

He was graduated from Hastings (Nebraska) College and received his M. D. Degree in 1963 from the University of Chicago School of Medicine.

His wife, Dr. Lois V. Svoboda, is a general practitioner with the WVU Health Service.

Also speaking during the first general session, in addition to Doctor Robinson, will be Dr. Joseph W. Burnett of Baltimore, Professor and Chairman, Department of Dermatology, University of Maryland School of Medicine, whose topic will be "Diagnostic Dermatologic Methods," and Dr. Harry M. Robinson, Jr., also of Baltimore, Professor Emeritus, Department of Dermatology, University of Maryland School of Medicine, "Advances in Photochemotherapy."

The other two speakers and topics for the second general session Friday morning, in addition to Doctor Svoboda, will be "The Primary Physician's Role in Care of the Chronically Mentally Ill"—Dr. Rogers J. Smith, Portland, Oregon, Psychiatrist and Chairman, American Medical Association Council on Scientific Affairs; and "Meeting the Needs of the Chronically Mentally Ill at the Community Level"—Dr. Patrick R. Staunton, Chairman of the Division of Psychiatry, Luthern General Hospital, Park Ridge, Illinois.

## Greenbrier Reservations Due By July 5

Reservations for the 113th Annual Meeting of the West Virginia State Medical Association should be made with the Greenbrier no later than Saturday, July 5, in order to comply with the hotel's requirement that all reservations must be received no later than 45 days prior to the meeting. Reservation forms provided by the Greenbrier have been distributed to all Association members. Any physicians who need additional forms should write or call the Association's headquarters office in Charleston.

### Talks on AMA Services, Activities

Talks on AMA services and the activities of the AMA's Washington, D. C., office are scheduled for the third and final general session Saturday morning.

The general convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 22).

Plans also call for the usual President's Reception on Wednesday evening, August 20, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P. M. on Saturday. At that House session, Dr. L. Walter Fix of Martinsburg will be inaugurated as President to succeed Dr. Stephen D. Ward of Wheeling.

### Auxiliary to Meet

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. D. Sheffer Clark of Huntington in charge as the Auxiliary's President, again will run concurrently with the Association's convention.

Members of the Program Committee are Dr. M. D. Reiter of Wheeling, Chairman; Doctor Fix, and Drs. David K. Heydinger of Marshall University's School of Medicine in Huntington; Joseph B. Reed, Buckhannon; Stanley Roy Shane of the West Virginia University School of Medicine faculty in Morgantown, and John F. I. Zeedick of South Charleston.

## Medical Association Honors Former Health Director

N. H. Dyer, M. D., M.P.H., West Virginia's health director from September, 1946, to mid-1977, was honored by the West Virginia State Medical Association at the Mercer County Medical Society's April meeting.

Doctor Dyer, now a Princeton resident, was presented with a plaque by the Association's Executive Secretary, Charles R. Lewis, who was covering the State Capitol for United Press at the time Doctor Dyer assumed his Department of Health duties.

The inscription on the plaque reads: "The West Virginia State Medical Association Expresses Heart-Felt Gratitude to N. H. Dyer, M. D., M.P.H., for a Lifetime of Dedicated Service to West Virginians and his Profession."

## Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb. Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal).

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

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| June 7 | Morgantown | Anesthesia Update '80 |
| June 7 | Charleston | 7th Annual Surgery Conference |
| June 13-14 | Charleston | Cytology/Pathology Regional Workshop |
| July 12 | Charleston | CAMC Oncology Symposium: Update on the Management of Melanoma |

### Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

*Cabin Creek* (2nd Wed., 8-10 A. M.)

June 11

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| Emergency Medicine | Jack R. Page, M. D. |

July 9

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| Common Gynecological Disorders | Narinder N. Sehgal, M. D. |

*Welch, Stevens Clinic Hospital* (3rd Wed., 11 A. M.-1 P. M.)

June 18

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| Pulmonary Medicine: COPD Treatment | Dominic J. Gaziano, M. D. |

July 24

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| Common Gynecological Disorders | Narinder N. Sehgal, M. D. |

*Whitesville* (4th Wed., 10 A.M.-Noon)

June 25

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| Electrocardiogram and the Outpatient Management of Arrhythmias | Maria T. Georgieve, M. D. |

*Buckhannon, St. Joseph's Hospital* (4:30-6 P. M.)

June 19

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| Interactive Relationship of Commonly Prescribed Drugs | Carl Malanga, Ph. D. |

## Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*Handbook of Poisoning: Prevention, Diagnosis and Treatment, 10th Edition*, by Robert H. Dreisbach, M. D., Ph.D. 578 pages. Price $9. Lange Medical Publications, Los Altos, California 94022. 1980.

*General Ophthalmology*, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 410 pages. Price $15. Lange Medical Publications, Los Altos, California 94022. 1980.

*Current Pediatric Diagnosis and Treatment, 6th Edition*, by C. Henry Kempe, M. D.; Henry K. Silver, M. D.; and Donough O'Brien, M. D. 1122 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1980.

*Review of Medical Microbiology, 14 Edition*, by Ernest Jawetz, Ph.D., M. D.; Joseph L. Melnick, Ph.D.; and Edward A. Adelberg, Ph.D. 592 pages. Price $14. Lange Medical Publications, Los Altos, California 94022. 1980.

## WVU Graduates' Residency Selections Announced

Nearly half of this year's 91 graduates of the West Virginia University School of Medicine will remain in the state for their residency training.

Of the 45 who will take postgraduate training in West Virginia, 21 will remain at the WVU Medical Center and 17 will enter programs at the Charleston Area Medical Center. Five chose Wheeling Hospital's Family Practice program while one each will enter Family Practice programs at the Clarksburg United Hospital Center and the Kanawha Valley center.

Primary care specialties were the choice of 29, or 66 per cent, of those remaining in West Virginia.

This trend was reflected among all graduates with 52, or 57 per cent, choosing all or part of their training in family practice, internal medicine or pediatrics.

Internal medicine was the choice of 23, family practice was second with 18, and pediatrics was elected by eight.

Three graduates will enter dual residencies — two with internal medicine-behavioral medicine and psychiatry programs, and one with an internal medicine-obstetrics-gynecology combination.

Other residency choices were: surgery, 9; behavioral medicine and psychiatry, 7; obstetrics-gynecology, 6; anesthesiology, 4; neurology, 3; orthopedic surgery, 3; radiology, 3; pathology, 2; ophthalmology, 1; and physical medicine and rehabilitation, 1.

Jeffrey B. Young of Morgantown, a member of the class of 1979 who did not choose a residency last year, will enter the family practice program at the WVU Medical Center.

Members of the class of 1980, their hometowns and destinations are:

Dennis W. Allen, Weirton, WVU Department of Anesthesiology; David E. Allie, Logan, Charleston Area Medical Center (CAMC); Richard M. Allman, Parkersburg, WVU Department of Medicine; Michael A. Amadei, Vineland, N. J., Tucson (Ariz.) Hospital; Rita W. Arbuckle, Lewisburg, University of Kentucky Medical Center, Lexington; James E. Burgess, Charleston, State University of New York Upstate Medical Center, Syracuse; Michael W. Burkhart, Martinsburg, Wheeling Hospital; Carl D. Burkland, Morgantown, WVU Department of Family Practice.

Christopher E. Byard, Huntington, University of Alabama Medical Center, Birmingham; Richard A. Capito, Weirton, and James W. Caudill, Charleston, CAMC; Michael H. Chancey, Ripley, Akron (Ohio) Children's Hospital; Helene A. Cole, Great Neck, N. Y., North Shore University Hospital, Manhasset, N. Y.; Barbara A. Cooper, Lewisburg, CAMC; William F. Coppula, Bridgeport, Mercy Hospital, Pittsburgh; William D. Cutlip II, Richwood, WVU Department of Pediatrics; James L. Comerci, Weirton, Wheeling Hospital.

**New officers of the West Virginia Chapter, American Academy of Family Physicians were elected during the recent 28th Scientific Assembly of the Chapter in Morgantown. From left, are Drs. Joseph A. Smith, Dunbar, AAFP Delegate; L. Dale Simmons, Clarksburg, AAFP Alternate Delegate; Del Roy R. Davis, Kingwood, AAFP Delegate and recipient of this year's "Mr. Doc" Award, the Chapter's highest honor; Wilbur Z. Sine, Morgantown, Director, District II; Dewey F. Bensenhaver, Petersburg, Director, District III, William H. Harriman, Jr., Terra Alta, Treasurer; John L. Fullmer, Morgantown, President; A. Paul Brooks, Jr., Parkersburg, Secretary; Thomas P. Long, Man, Chairman of the Board; Thomas L. Ritz, Wheeling, President Elect, and Robert D. Hess, Clarksburg, Vice President.**

John E. Davis III, Charleston, WVU Department of Anesthesiology; Richard L. Davis, Parkersburg, WVU Department of Family Practice; Thomas E. Davis, Chapmanville, University of Kentucky Medical Center; Stanley T. Day, Westover, Spartanburg (S. C.) General Hospital; Thomas A. Durnell, Parkersburg, Cincinnati (Ohio) General Hospital; John D. England, Clarksburg, Medical University of South Carolina, Charleston; Haywood G. France, Jr., South Charleston, CAMC; Janice K. Friend, Grafton, University of California Hospitals, San Francisco; Jane C. Gerke, South Charleston, Hahnemann Medical Hospital, Philadelphia;

Michael F. Godschalk, Huntington, and David M. Gray, Charleston, CAMC; John O. Grimm, Le Plata, Md., Indiana University Medical Center, Indianapolis; Bruce P. Guido, Fairmont, and Charles D. Guy, Philippi, CAMC; Stephan D. Hanna, Pt. Pleasant, Akron (Ohio) City Hospital; Daniel P. Harrington, Beckley, University of Virginia Hospital, Charlottesville; David A. Henderson, Summersville, William Shands Teaching Hospital, University of Florida, Gainesville.

Raymond B. Henthorn, Charleston, CAMC; Alter J. Herbert, Charleston, University of Kentucky Medical Center; Stephen T. Hill, St. Marys, Akron (Ohio) City Hospital; John M. Holbert, Bridgeport, WVU Department of Family Practice; Eric M. Humphreys, St. Albans, CAMC; Michael W. Jopling, Elkview, WVU Department of Anesthesiology; Blair H. Kokotek, Barboursville, St. Vincent's Hospital and Medical Center of New York; Terry D. Koubek, South Charleston, North Carolina Baptist Hospital, Winston-Salem.

Jeffrey A. Kugel, Charleston, Vanderbilt University Hospital, Nashville, Tenn.; Rex D. Lasure, St. Albans, WVU Department of Family Practice; Richard D. Layne, Williamson, WVU Department of Medicine; Sharon R. Leham, Parkersburg, Georgetown University Hospital, Washington, D. C.; Roger A. Lewis, Terra Alta, Franklin Square Hospital, Baltimore; Donald R. Lilly, Falls Church, Va., University of Virginia Medical Center; Donna S. Lilly, Falls Church, Va., CAMC; Mari L. Lilly, Huntington, University of Tennessee Clinical Education Center, Chattanooga; Steven A. Lovejoy, Charleston, CAMC.

Bernard J. Luby, Charleston, CAMC; John R. Marler, Franklin, WVU Department of

(Continued on page xviii)

## Florida Educator Named MU CME Coordinator

Dr. Charles W. Jones, formerly on the faculty of Central Florida Community College, has been named Coordinator of Continuing Medical Education at Marshall University's School of Medicine.

Doctor Jones, who already has assumed the post, also holds rank as Assistant Professor in the Community Medicine Department, according to Dr. Robert W. Coon, MU Medical School Dean.

Charles W. Jones, Ph. D.

A native of Georgia, Doctor Jones taught in the Special Services Department, Social Science and Psychology Division, at Central Florida Community College in Ocala. He earned the Ph. D., the Education Specialist, the Master of Education and the Bachelor of Arts degrees from the University of Florida at Gainesville.

"The establishment of a centralized coordinating office for the Medical School's Continuing Medical Education programs is the first of several steps we have initiated to fulfill our commitment of providing quality continuing education programs which are easily accessible to the region's physicians," Doctor Coon said.

"We've also set up an advisory committee for Continuing Medical Education, which will oversee the total program, and each separate conference will be planned by an ad hoc committee, composed of members of our full-time and clinical/volunteer faculty," the Dean added.

"We will be working closely with the education committees at our teaching hospitals and we plan to develop similar relationships with other hospitals and health agencies in the region," Doctor Coon said.

### Accreditation Objective

Doctor Jones said one of his major objectives will be obtaining accreditation for Marshall's Community Medical Education programs from both the American Medical Association Committee on Accreditation of Continuing Medical Education and the Liaison Committee for Continuing Medical Education.

A conference on "Geriatric Medicine: Today and Tomorrow" already has been scheduled for

October 16-17 and will feature several nationally-known figures in the field as speakers. Other continuing medical education conferences are being planned, Doctor Jones said.

"Continuing Medical Education is undergoing a philosophic change right now, and for Marshall, as it begins to build from ground level, the opportunities involved in being in the forefront of this change are great," he noted.

"While attempting to develop innovative programs and ways to deliver them—especially to rural primary care physicians—I not only want to create a Tri-State Area awareness that the quality of research and teaching here is significant, but also have this quality recognized nationwide," he added.

## Medical School Applicant Supply Seen As Coming Problem

West Virginia University has no problem attracting highly qualified Medical School applicants, according to the Dean of the WVU School of Medicine, but there's no guarantee that picture won't change.

"We have no problem now and I don't foresee any in the immediate future," Dr. John E. Jones said.

The acceptance ratio at WVU last year was one to 2.9 applicants compared to an average of one to 2.2 for the nation's 125 medical colleges.

But Doctor Jones said a steady decline in the national pool of applicants, a decline also reflected in West Virginia—and coming at a time when slots available in West Virginia are scheduled to increase—could mean trouble ahead.

WVU now admits 88 students per year, the Marshall University Medical School, 36, and the West Virginia School of Osteopathic Medicine at Lewisburg, 60. Under goals fixed by the State Board of Regents, WVU's total is to increase to 120 and Marshall's to 48, raising the overall state total from 184 to 228.

"When I look ahead to the time that classes are expanded, I see problems," Doctor Jones said.

"On the basis of our experience at WVU during the past 20 years, there appears to be about 120 highly qualified applicants from West Virginia each year, plus or minus 20. Thus, all of our experience suggests that the pool of qualified people won't be adequate to support the higher enrollment figures.

"This is especially true in light of the national picture where the total number of applicants has dropped from 42,000 to 36,000 during the past five years, and the acceptance rate has jumped from 35 per cent to 45 per cent.

"The forecasts are of great concern to me," Doctor Jones said, "because what all these figures mean is that we will have to go much deeper into the pool of applicants or the Regents will have to consider expanding the number of out-of-state residents enrolled in our medical education programs."

### Decline Predicted

Dean Jones noted that two years ago the Chronicle of Higher Education reported that "after enjoying an oversupply for more than a decade, medical schools are beginning to experience a severe decline in applications that could become chronic over the next few years."

"The shift away from medical studies so worries the medical school association that it will urge its members to adopt strategies immediately to cope with the potentially alarming consequences," the Chronicle said. "By 1980 there could be a precipitous drop," a top official of the Association of American Medical Colleges was quoted.

Doctor Jones also said the recent report that some students with grade-point averages (GPA) under 3.0 have been accepted at West Virginia medical schools "has been exaggerated in the minds of many people. The GPA of the last four entering classes at the WVU School of Medicine was 3.56, a strong B-plus."

MCAT (Medical College Admission Test) scores of entering classes at WVU are above the national average of medical school applicants nationwide, and only an occasional and exceptional "C" student has ever been enrolled.

"But because we're the largest and most visible of the state's medical institutions, our first-year class is concerned that a totally false impression of their ability is being reported nationwide," he said.

"The headlines on one recent wire service report came out like this—'Med School Classes Aren't Filling,' 'Medical Schools Beg for Students,' and 'W. Va. Medical Schools Can't Fill Vacancies.'

"The situation is worrisome enough as we look down the road without having things twisted out of shape," Dean Jones said. "And it adds insult to injury to cast doubt on the ability of WVU medical students who more than met the national standard."

## Dues Hike Sought To Offset Inflation, Service Needs

In the face of inflation and increasing demands on it for a wide variety of services, the West Virginia State Medical Association leadership will ask its House of Delegates to approve in August the first dues increase for members since 1975.

The Association's Executive Committee and Council voted at April 12-13 meetings in Charleston to recommend to the House a $100 increase, to $250, for the new dues and Association year to begin January 1, 1981.

The Committee and Council reviewed in detail the Association's financial picture since 1974 House action raised state dues from $100 to $150 in 1975.

That review showed success in building up reserve funds in 1976, 1977 and 1978. The necessary addition, for the first time in some 25 years, of another administrative staff member in mid-1979, and the impact of double-digit inflation, now have cut heavily into those reserves.

The Association, with a current staff of six and total membership approaching 2,200, also has seen significant demands on it in such areas as state and federal legislative activity; increased problems stemming from state and federal regulations; a need to deal with state welfare and other programs in increased measure; continuing medical education; the broadening scope of health planning, and new activity in professional liability insurance.

In addition, with Council and House approval, the Association invested $78,000 of its reserves in real estate in Charleston in 1979 as the first step in planning for its own headquarters and office building.

The Association leadership anticipates that approval of the proposed $100 dues increase for 1981 can restore the general operating budget to manageable levels for the next few years.

At the same time the increase can provide some operating margin for additional services, and for meeting unexpected contingencies which might arise from such directions as litigation in which the Association might become involved.

#### Other Council Action

In other action at its April 13 meeting, the Council:

—Endorsed an effort by the Association's State Office to obtain between-sessions review by a legislative interim committee of financial and other problems plaguing the Department of Welfare's Medical Service Program. This review has been obtained, as detailed by a story in the General News Section of *The Journal's* May issue.

—Approved distribution of minutes of Council Meetings to secretaries of component medical societies as a further step toward better communications within a growing organization.

—Heard plans to seek election of Harry S. Weeks, Jr., M. D., of Wheeling to the American Medical Association's Council on Medical Service during the annual meeting of the AMA House of Delegates in Chicago in July.

—Elected to honorary membership, after appropriate component society action, Drs. Harold H. Howell of Madison (Boone County); W. T. Booher, Sr., Wellsburg (Brooke); Marvin R. Houck, Carbon (Kanawha); G. Thomas Evans, Fairmont (Marion); and the following Parkersburg Academy of Medicine members: Watson F. Rogers and Randall Connolly, both of Vienna; Richard Hamilton, St. Marys, and Marion S. Brown, R. D. Lattimer, Robert C. Lincicome, Michael A. Santer, Sr., Ray H. Wharton and A. C. Woofter, all of Parkersburg.

—Elected to retired membership Drs. Mary V. Gallagher and Seigle W. Parks, both of Charleston, and Tracy N. Spencer of South Charleston (all of Kanawha) and H. A. Rich, Morgantown (Monongalia).

—Provided active member-dues exempt status for Dr. Charles W. Nelson of Beckley because of illness.

## PICO Insurance Proposal Received By Council

The Medical Association Council received, at its April 13 meeting in Charleston, a proposal from Physicians Insurance Company of Ohio (PICO) detailing how that company could help West Virginia physicians set up a doctor-owned malpractice insurance company.

The presentation was made by Senior Vice President David Rader of PICO, who said his company would provide at a later date premiums it would propose if the Medical Association should decide to enter into a multi-phase insurance project with PICO.

Council referred the PICO material to its Ad Hoc Committee on Professional Liability Insurance, chaired by Jack Leckie, M. D., of Huntington, for further study and a recommendation contingent upon receipt of proposed PICO premiums.

## Continuing Education Program At WVU Reaccredited

The West Virginia University School of Medicine has been notified of reaccreditation of its continuing medical education program by the American Medical Association.

Assistant Dean Robert L. Smith, M. D., said this accreditation would continue for the next four years, after which the program would be re-surveyed. The School was first accredited for continuing medical education in June, 1976.

During the past year, 42 weekly activities of from one to two hours' duration were available for physicians to attend for Category 1 credit acceptable for the AMA's Physician's Recognition Award.

Category 1 credit is given for participation in sponsored, accredited continuing medical education. Categories 2 through 6 recognize other learning experiences. A minimum of 60 hours must be earned in Category 1, although all 150 hours required for the award may be earned in this category.

In addition to ongoing weekly activities, 15 to 20 short courses of one or two days' duration are conducted each year at the WVU Medical Center or other area facilities.

Monthly outreach programs are conducted from the Medical Center and its Charleston Division for physicians in Buckhannon, Weston, Clarksburg, New Martinsburg, Welch, Whitesville, Cabin Creek, Fairmont and Ripley.

**Edmund C. Settle, Jr., M. D., of Charleston, second from left, was the winner of the Taylor Manor Hospital Essay Award for residents in April. The award was presented in conjunction with the 1979-80 Psychiatric Symposia Series conducted by the hospital, located in Ellicott City, Maryland. Hospital officials with Doctor Settle are, from left, Frank J. Ayd, Jr., M. D., Director of Professional Education and Research, Symposium Director; Irving J. Taylor, M. D., Medical Director; and Bruce T. Taylor, M. D., Director of Admissions.**

A toll-free telephone line into the Office of Continuing Medical Education is available to physicians in the state to request consultation with School of Medicine faculty in patient care or management. Such requests are followed up with copies of pertinent scientific literature from the Medical Center library.

Doctor Smith said continued accreditation also is being sought from the Liaison Committee on Continuing Medical Education, which is composed of representatives from the Association of American Medical Colleges and national medical groups other than the AMA.

## Two-Day Female Genital Tract Workshop Scheduled

A two-day workshop on Female Genital Tract Cytology and Cytopreparation will be held June 13-14 at the West Virginia University Medical Center Education Building in Charleston.

Hosts will be the Department of Pathology, Charleston Area Medical Center, and the Charleston Division, WVU Medical Center.

The program is sponsored by the American Society of Cytology and the American Cancer Society.

The workshop will present cytopreparatory techniques, microscopic interpretation and clinical cytopathological correlation. Common diagnostic entities will be emphasized, and recognition criteria and differential diagnosis stressed. Lectures will be demonstrated by photomicrographs.

The program will be co-directed by John K. Frost, M. D., and Gary W. Gill, CT (ASCP), CMIAC, both of Baltimore. Doctor Frost currently is Professor, Department of Pathology and Department of Gynecology and Obstetrics at The Johns Hopkins University School of Medicine.

In 1972, Doctor Frost was awarded The Papanicolaou Award for Meritorius Achievement in Cytology of the American Society of Cytology, the highest honor in Cytopathology in North America and, in 1979, The Goldblatt Award for Education and Research on Clinical Cytology by the International Academy of Cytology, the highest international honor in clinical cytology. He is the author of 64 scientific articles, books and laboratory manuals and has prepared more than 90 audio visual educational productions in his field.

Mr. Gill presently is Chief Research Associate at The Johns Hopkins Medical Institutions' Cytopathology Laboratories, and the Technical Administrator of the Johns Hopkins Medical Institutions' Early Lung Cancer Detection Project. He too has authored many publications on various cytopreparatory techniques and has participated in several educational film productions. He has lectured extensively throughout the United States.

This workshop, presented with funds from the American Cancer Society, is open to all persons involved in the field of clinical cytology and to all obstetricians-gynecologists. No fees will be charged.

For additional information, contact Sharon Hall, Conference Coordinator, Charleston Division, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304. Telephone (304) 347-1242.

## Lithium Treatment Saves Americans $4 Billion

Use of lithium in the successful treatment of manic-depression has not only rescued thousands of individuals from serious illness, but also has saved some $4 billion in treatment costs and gained production during the last 10 years.

This is the conclusion of researchers from the National Institute of Mental Health and St. Elizabeth's Hospital, Washington, D. C., in a report in a recent issue of an American Medical Association specialty journal, Archives of General Psychiatry.

Lithium was approved by the Food and Drug Administration as a treatment for manic excitement in 1969. At that time, some 32,750 hospital beds were occupied for treatment of manic-depression, said Ann Reifman and Dr. Richard Jed Wyatt. Only estimates are available for those then being treated as out-patients.

Miss Reifman and Doctor Wyatt estimate that lithium treatment, which has freed manic patients from hospitals and returned them to everyday life, has saved $2.88 billion in 10 years in treatment costs. For those individuals who were able to return to work and family, there was a gain of $1.28 billion in production, they estimate.

Today, manic-depressive patients do strikingly better on lithium than when they were treated with hospitalization, electrotherapy and many different drugs. It renders an overwhelming majority of manic-depressive patients free from their previous mental anguish and able to function smoothly in society, the researchers declare.

"Just as good nutrition and penicillin began to empty psychiatric wards of the victims of pellegra and syphilis and drastically reduce the costs of these diseases, lithium decreased the cost of manic-depression," they comment.

The estimate of $4 billion savings is speculative, but, if anything, probably much too low, they conclude.

## *Medical Meetings*

June 15-17—Am. Diabetes Assn., Washington, D. C.

June 18-20—Endocrine Society, Washington, D. C.

June 18-21—Art & Science of Sports Med., '80 (U. of Va.), Charlottesville.

June 24-27—Society of Nuclear Med., Detroit.

July 14-16—NIH Consensus Development Conference on Adjuvant Chemotherapy of Breast Cancer, Bethesda, Md.

July 20-24—AMA House, Chicago.

July 23-25—NIH Consensus Development Conference on Cervical Cancer Screening: The Pap Smear, Bethesda, Md.

Aug. 7-8—2nd Annual Sports Med. Clinic (MCV), Richmond, Va.

**Aug. 20-23—113th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.**

Sept. 3-6—Am. Assn. of Obstetricians & Gynecologists, Hot Springs, Va.

Sept. 4-5—Diagnostic Ultrasound in Obstet.-Gynecol., Johns Hopkins, Baltimore.

Sept. 8-10—Am. Neurological Assn., Boston.

Sept. 21-25—Am. College of Radiology, New Orleans.

Oct. 6-9—AAFP, New Orleans.

Oct. 9-11—Am. Cancer Society, Los Angeles.

Oct. 10-12—Pediatric Approach to Common Neurological Problems (Johns Hopkins), Ocean City, Md.

Oct. 17-19—AMA Regional Meeting, Huron, Ohio.

Oct. 19-24—ACS Clinical Congress, Atlanta.

Oct. 24-26—AMA Regional Meeting, Philadelphia.

Oct. 26-30—Am. College of Chest Physicians, Boston.

Nov. 2-7—Am. Academy of Ophthalmol., Chicago.

Nov. 12-15—Am. Heart Assn., Miami.

Nov. 14-16—AMA Regional Meeting, New York City.

**1981**

**Jan. 23-25—14th Mid-Winter Clinical Conference, Charleston.**

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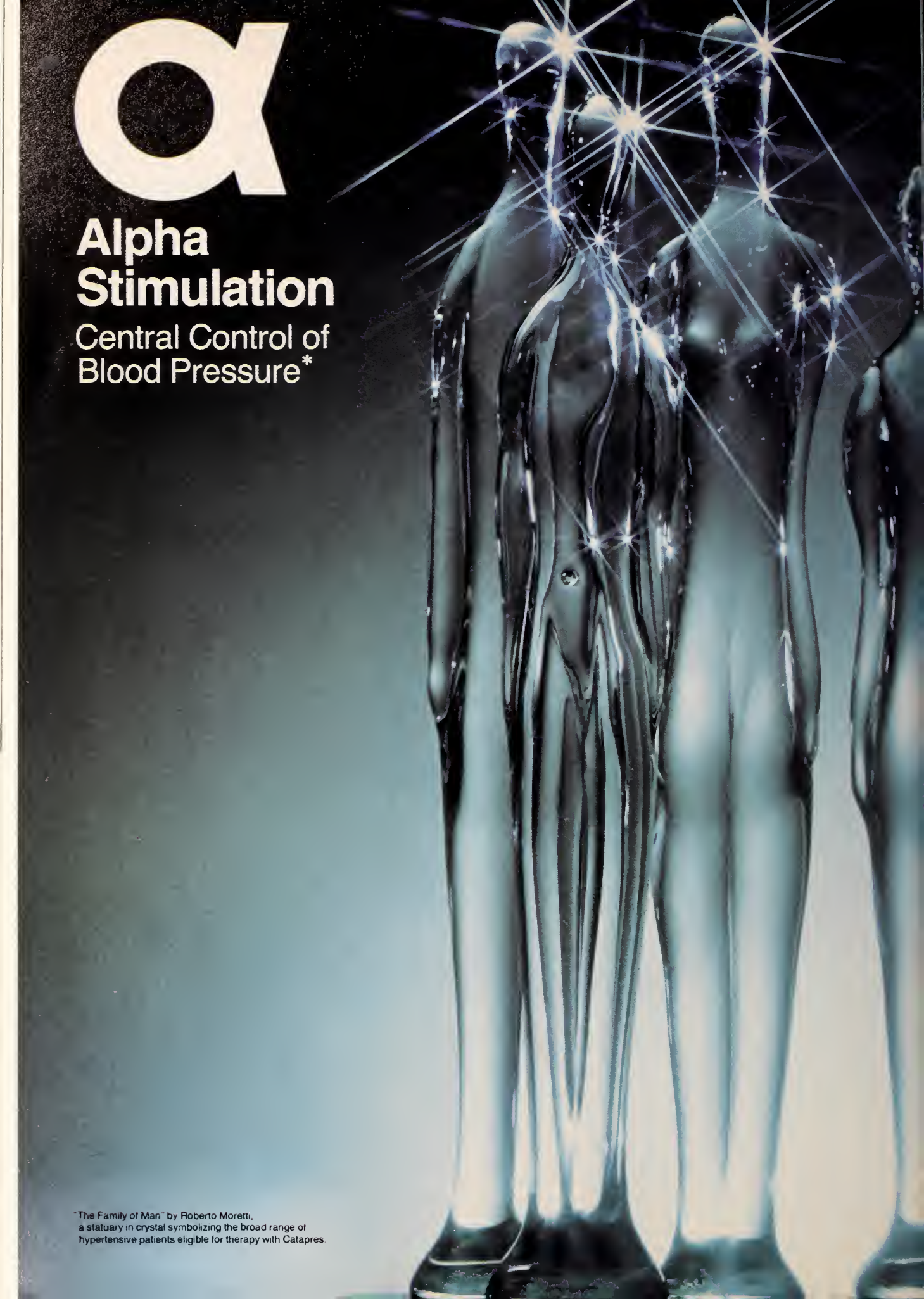
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| Bronchial asthma | Sulfonamide hypersensitivity |

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

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**love**—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

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Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

[1] Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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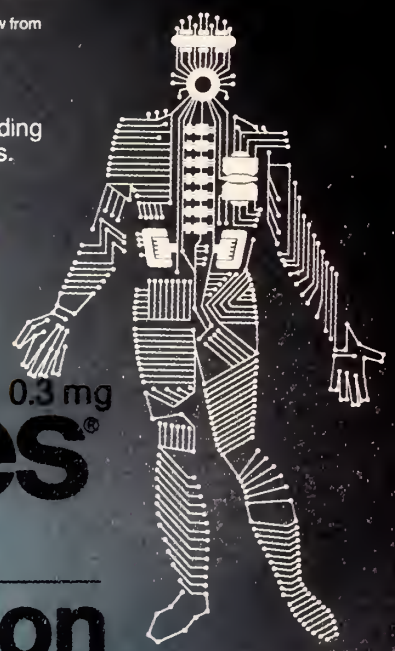

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(clonidine HCl)

## Hypertension

# The Alpha Advantage:

## It's for all kinds of hypertensives

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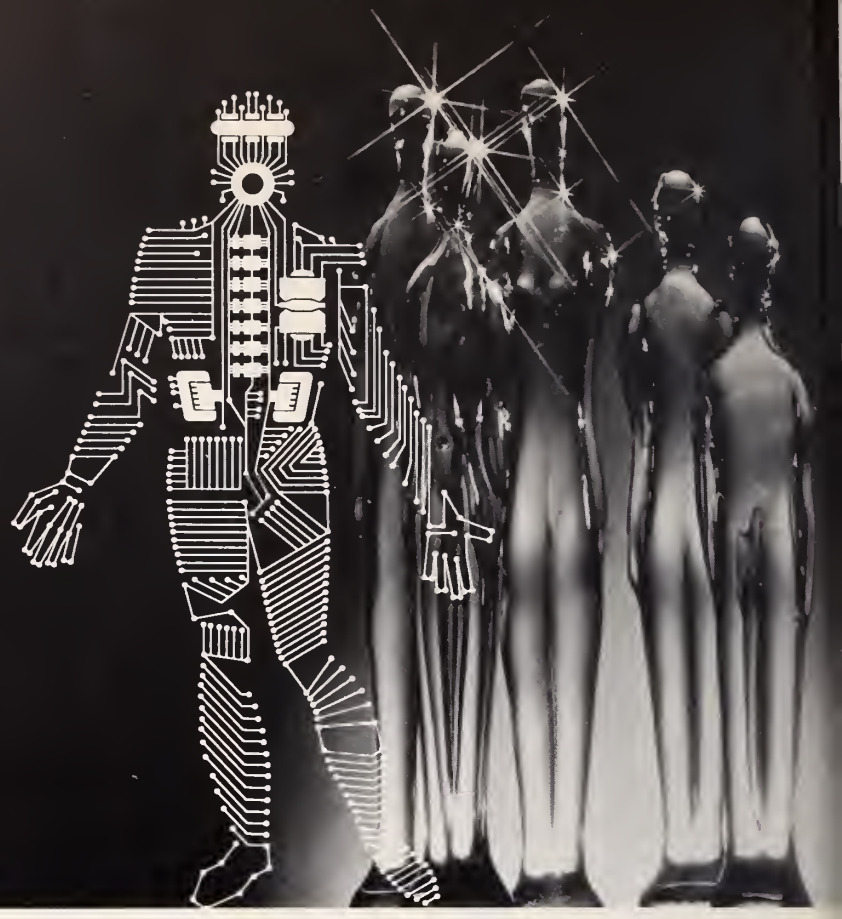
# Catapres®

(clonidine HCl)

## Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

**Catapres®**
**(clonidine hydrochloride)**
**Tablets of 0.1, 0.2, 0.3 mg**

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
*Usage in Children:* No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsiness a sedation. Constipation, dizziness, headache, and fatigue have been reporte Generally these effects tend to diminish with continued therapy. The followi reactions have been associated with the drug, some of them rarely. (In so instances an exact causal relationship has not been established.) These inclu Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities liver function tests; one report of possible drug-induced hepatitis without icte and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chl thalidone and papaverine hydrochloride. Weight gain, transient elevation of blo glucose, or serum creatine phosphokinase: congestive heart failure, Raynau phenomenon; vivid dreams or nightmares, insomnia, other behavioral chang nervousness, restlessness, anxiety and mental depression. Also rash, gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associat with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryne itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomast weakly positive Coombs' test, asymptomatic electrocardiographic abnormalit manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished or a sent reflexes and vomiting followed the accidental ingestion of Catapres (clonid hydrochloride) by several children from 19 months to 5 years of age. Gas lavage and administration of an analeptic and vasopressor led to complete covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-min intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) ov dosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0.1 m (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. A available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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# WVU Medical Center
# –News–

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## Grant To Promote Primary Care Goes To WVU

The Robert Wood Johnson Foundation recently announced a $783,578 grant to WVU School of Medicine to promote primary care programs offered by the WVU Hospital clinics.

It is one of the largest grants the WVU Medical Center has ever received from a private foundation. WVU President Gene A. Budig said it "moves the Medical Center much closer to the national recognition it so clearly deserves."

The grant was one of 15 totaling $12 million by the medically-oriented foundation to be spent over a four-year period. Other recipients included the university teaching hospitals of Vanderbilt, Yale, Johns Hopkins, UCLA, Georgetown, the University of California at San Francisco and Mount Sinai of New York.

A Foundation spokesman said the grants will permit the teaching hospitals to replace their general medicine clinics with physician group practices to provide around-the-clock, personalized care on a continuing basis.

### Hospital Outpatient Settings

Foundation President David E. Rogers, M. D., noted that a fourth of all visits to physicians in this country last year were made in hospital outpatient settings—a 50 per cent increase in the past 10 years. Teaching hospitals make up only five per cent of all hospitals, but accounted for a fourth of such ambulatory care visits.

"These institutions were not designed for, nor their staffs recruited or organized to serve as the personal physician for thousands of people," Doctor Rogers said.

Most have a large variety of specialty clinics dealing wtih specific diseases, and patients are sometimes shuttled between clinics. Even where there is a general medicine clinic, the physician staff often serves on a rotating basis so that "rarely does a patient have a single physician develop an overall plan of care," he observed.

"We hope this new program will enable these 15 institutions to turn their attention to this situation and better provide high-quality, continuous care," Doctor Rogers continued.

Each of the group practices, staffed by full-time faculty from the division of general medicine of the hospital's affiliated school, also will become a center for expanded residency training "and will give young residents a much more realistic and appealing setting in which to learn ambulatory care."

The group practice at West Virginia University Hospital is under the direction of Dr. Robert M. D'Alessandri, who noted that WVU "had gone the primary care and group practice route long before the application was made."

President Budig noted, too, that the WVU Medical Center "has a tradition of promoting primary care, and in a competition that included more than 40 per cent of the nation's medical colleges it was judged one of the 15 most outstanding in that area."

A total of 51 medical colleges with teaching hospitals had applied for the grants.

Doctor D'Alessandri said 6,000 patient visits were recorded by the General Medicine Group Practice during the past fiscal year and 10,000 are expected this year.

Each patient has a regular attending physician and is seen by that doctor on each visit. The attending physicians are faculty members who are board-eligible or board-certified in internal medicine. They devote about 80 per cent of their time to the group practice.

## Performs Surgery In Taiwan

Procedures for dissection of intracranial aneurysms were performed by John L. Fox, M. D., Professor of Neurosurgery, at hospitals in Taipei, Taiwan, during his recent two-week stay in the Republic of China.

Doctor Fox was in Taipei at the invitation of Albert Ly-young Shen, chief neurosurgeon. His trip was made possible through a grant from the Tjing-Ling Neurological Foundation of the Veterans General Hospital in Taipei.

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# Third-Party News, Views and Program Concerns

## AMA Not Supporting Fee Guidelines

Citing the success of physicians' voluntary effort to restrain their fees over the past two years, American Medical Association Executive Vice President James H. Sammons, M. D., recently told U. S. Department of Health and Human Services (HHS) officials that the AMA would be unable to support Council on Wage and Price Stability guidelines setting a 6.5 per cent rate of increase for 1980. The rate of inflation appears to be about 18 per cent, he pointed out, and the COWPS wage guidelines are 7.5 per cent to 9.5 per cent.

The AMA will continue to urge individual physicians to exercise restraint, a policy that has resulted in increases well behind the Consumer Price Index figures for the economy in general, he said. The CPI rose 9.0 per cent in 1978 while physicians' fees were rising 8.1 per cent, and in 1979 the CPI went up 13.3 per cent while fees were increasing 9.4 per cent.

Doctor Sammons' comments came at a Washington meeting of leaders of the Voluntary Effort to Contain Health Care Costs with HHS officials led by John Palmer, Assistant Secretary for Planning and Evaluation, and Karen Davis, Ph. D., Deputy Assistant. Also at the meeting were Alex McMahon, President of the American Hospital Association; Michael Bromberg, Executive Director of the Federation of American Hospitals; and Paul Earle, Executive Director of the VE.

HHS proposed a 13.4 per cent rate of increase for hospital expenditures in 1980, which is the same as the actual rate in 1979. COWPS and HHS will conduct a joint program for monitoring hospital rate increases, HHS reported. A system for monitoring physicians' fees has not yet been devised, the HHS officials said. They asked for AMA assistance in any monitoring program that might be set up, and the AMA agreed to another meeting on the subject.

## Increase In Fees Below Rate of Inflation

The rate of increase in physicians' fees in March was well below the rate of inflation in the general economy, according to the government's Consumer Price Index. The all-items and all-services components of the CPI rose 1.4 per cent and 1.8 per cent, respectively, while physicians' fees went up 0.8 per cent. The hospital room charge was up 0.6 per cent, and dental services rose 1.1 per cent.

The slowdown in the physician fee rate came after increases of 1.4 per cent in January and 1.6 per cent in February. Hospital room charge increases had been 1.5 per cent in January and 2.0 per cent in February. Over the past 12 months, physicians' fees have increased 10.4 per cent and hospital room charges have risen 12.3 per cent, while the all-items index has increased 14.7 per cent and the all-services index has risen 16.1 per cent.

## HEW Is Now HHS

The U. S. Health, Education and Welfare Department, abbreviated as HEW all these years, officially assumed a new name on May 7—the Department of Health and Human Services (HHS). That was the date the new Department of Education was launched, stripping the "E" out of the HEW.

The HHS acronym unfortunately looks a lot like the other acronyms that abound at the HEW Department, especially the HSA of the Health Services Administration. HEW was almost christened the Welfare Department at its inception in the early 1950s, but the late Senator Robert Taft, Republican of Ohio, balked at the implication of a welfare state.

113th ANNUAL MEETING

of the

# *West Virginia State Medical Association*

*The Greenbrier*

AUGUST 20-23, 1980

# PLAN NOW TO ATTEND

# Motrin® vs codeine...

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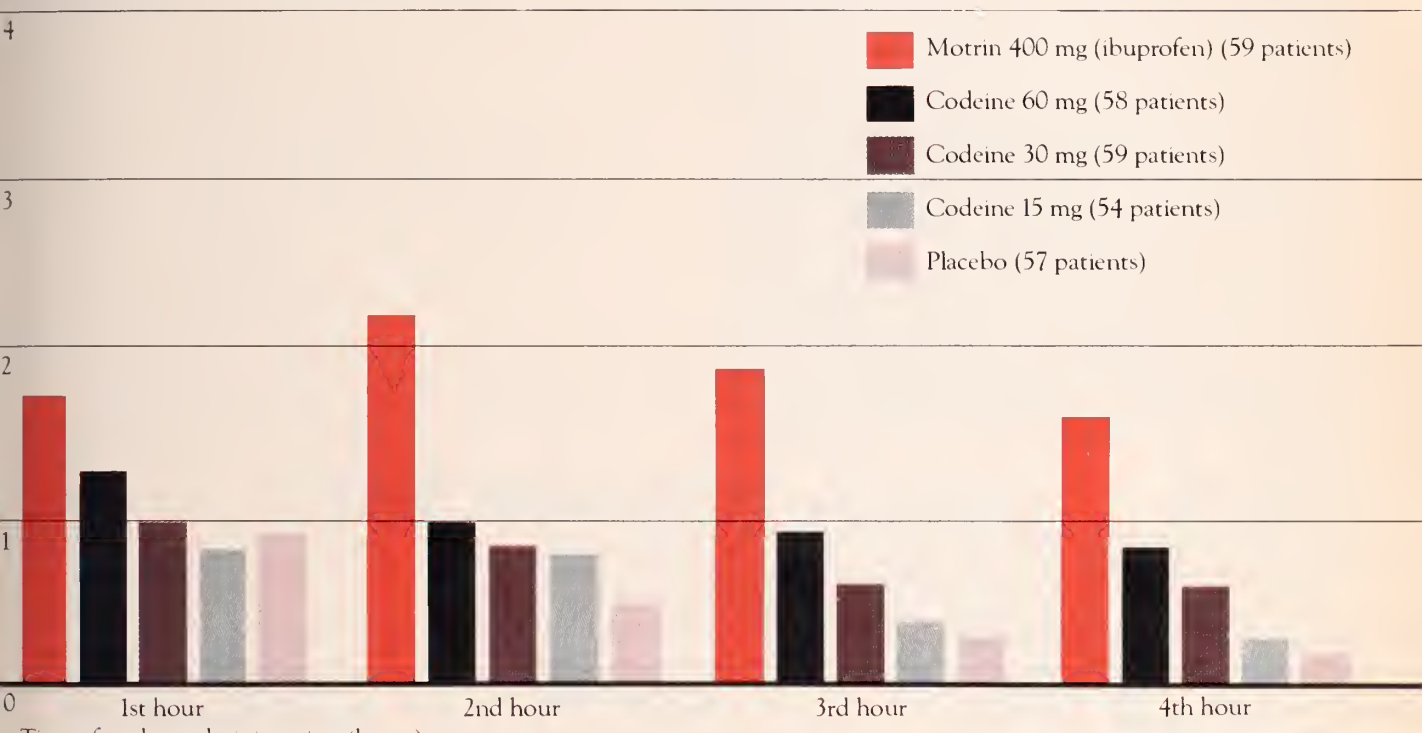
# compare the analgesic effect

*Motrin* (ibuprofen) 400 mg tablets provided greater relief of pain than codeine in a double-blind, randomized clinical study of 287 patients. *Motrin* was significantly more effective ($p < 0.01$) than codeine 60 mg at the 2-, 3- and 4-hour intervals...significantly more effective ($p < 0.01$) than codeine 30 mg, codeine 15 mg, and placebo at all intervals.

**Degree of pain relief—mean scores**

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief

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**A well-tolerated, nonnarcotic prescription for mild to moderate pain**

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**ibuprofen, Upjohn**

- Not a narcotic • Not addictive • Not habit forming • Acts peripherally
- Relieves pain rapidly • Indicated in acute and chronic pain • Well tolerated
- The most common side effect with *Motrin* is mild gastrointestinal disturbance.

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**Upjohn**

# Motrin® (ibuprofen)
# now proved an effective analgesic for mild to moderate pain

**Motrin® Tablets** (ibuprofen, Upjohn)

**Indications and Usage:** Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

**Adverse Reactions**

*Incidence greater than 1%*

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

*Incidence less than 1 in 100*

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

*Causal relationship unknown*

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

**Caution:** Federal law prohibits dispensing without prescription.

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Moseley H. Winkler, M.D.
Samuel A. Strickland, M.D.

**E.E.N.T.**
John B. Haley, M.D.
John A. B. Holt, M.D.

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Romeo Y. Lim, M.D.
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# THE GOLDEN CLINIC

**1200 Harrison Avenue**

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**ANESTHESIOLOGY:**
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**COMMUNITY MEDICINE:**
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S. O. Chung, M. D.
J. E. Cunningham, D. O. (Mount Storm & Riverton Clinics)
M. C. Rosenberg, D. O. (Helvetia Clinic)
L. E. Soriano, M. D. (Marlinton Clinic)
P. M. Tanna, M. D. (Green Bank Clinic)

**EMERGENCY MEDICINE:**
R. H. Plummer, D. O.
A. M. Fuller, M. D.
F. A. Khan, M. D.

**FAMILY PRACTICE:**
L. H. Valliant, M. D.
H. E. W. Gregor, M. D.

**INTERNAL MEDICINE:**
**Gastroenterology:**
S. S. Masilamani, M. D.
**Allergy & Rheumatology:**
J. B. Magee, M. D.
**Cardiology:**
H. L. Jellinek, M. D.
P. W. Gregor, M. D.
**Metabolic & Endocrine Diseases:**
F. Becerra, M. D.
**Pulmonary Diseases:**
J. C. Arnett, Jr., M. D.

**OBSTETRICS & GYNECOLOGY:**
H. H. Cook, Jr., M. D.
J. F. de Courten, M. D.
J. J. Rizzo, M. D.

**OPHTHALMOLOGY:**
J. N. Black, M. D.

**ORTHOPAEDIC SURGERY:**
J. G. Gomez, M. D.
D. R. Antonio, M. D.

**OTOLARYNGOLOGY (Facial Cosmetic and Reconstructive Surgery):**
N. Stronach, M. D.

**PATHOLOGY:**
M. M. Stump, M. D.

**PEDIATRICS:**
Y. J. Kwon, M. D.
R. J. Haas, M. D.

**RADIOLOGY:**
F. H. Abdalla, M. D.
H. Y. Mang, M. D.
C. P. O'Sullivan, M. D.

**SURGERY:**
**General, Thoracic & Vascular:**
J. A. Noronha, M. D.
W. B. Blum, M. D.
B. R. Blackburn, M. D.

**UROLOGY:**
D. T. Chua, M. D.

# Obituaries

### EDWARD SHUPALA, M. D.

Dr. Edward Shupala, Parkersburg ophthalmologist, died on April 3 in a Gainesville, Florida, hospital. He was 66.

A native of Pittsburgh, Doctor Shupala was a member of the staff at Camden-Clark Memorial Hospital and St. Joseph's Hospital in Parkersburg.

He was a Past President of the Parkersburg Academy of Medicine (1970-71) and the West Virginia Academy of Ophthalmology (1968-69). A board-certified member of the American Academy of Ophthalmology, he also was a member of the International College of Surgeons and an honorary member of the Parkersburg Academy of Medicine, West Virginia State Medical Association and American Medical Association.

Doctor Shupala received his undergraduate degree and M. D. degree (1946) from the University of Pittsburgh. He interned at St. Francis Hospital in Pittsburgh, took his residency at the Veterans Administration Hospital in Aspinwall, Pennsylvania, and did postgraduate work in ophthalmology at Colby College in Waterville, Maine.

Doctor Shupala was a member of the Wood County Board of Education from 1963 to 1973.

Survivors include the widow; the mother, Mrs. Anna Shupala of Pittsburgh; three daughters, Nancy Keister of Bedford Heights, Ohio; Barbara Lennon of Medina, Ohio, and Marjorie Shupala of Parkersburg; a brother, Robert Shupala of Erie, Pennsylvania, and two sisters, Rose Shupala and Mrs. Martha Kovac, both of Pittsburgh.

* * *

### EDWARD S. PHILLIPS, M. D.

Dr. Edward S. Phillips, Wheeling surgeon, died on April 30 in a Morgantown hospital. He was 67.

Doctor Phillips was a member of the staffs of Ohio Valley Medical Center and Wheeling, Martins Ferry, Reynolds Memorial and Wetzel County hospitals.

A native of Philadelphia, he had practiced in Wheeling for 41 years.

Doctor Phillips was graduated from Yale University and received his M. D. degree in 1938 from the University of Pennsylvania School of Medicine. He interned in Wisconsin and completed residencies and postgraduate work in surgery at the University of Pennsylvania, Saranac Lake, New York; Boston, and Bethesda, Maryland.

A World War II Navy veteran, Doctor Phillips was a member of the Ohio County Medical Society, West Virginia State Medical Association, American Medical Association, American College of Surgeons, International College of Surgeons and Southern Medical Association.

Survivors include the widow; a son, Dr. Edward B. Phillips of Denver; a daughter, Mrs. Thomas Watson of Woodbridge, Virginia; and three sisters, Mrs. E. H. Polack and Mrs. Stephen H. Pitkin, both of Wheeling, and Mrs. Arch T. Hupp of Morgantown.

* * *

### CHARLES I. ROGERS, M. D.

Dr. Charles I. Rogers, Charleston radiologist, was killed in an automobile accident on U. S. 60 east of Charleston near Malden on May 4. He was 33.

Also killed in the accident were Doctor Rogers' wife, Mrs. Ann Vargo Rogers, and their

(Continued on page xviii)

**OPENINGS**
**AT**
**THE MYERS CLINIC**
**Philippi, West Virginia**
**IN**
**Family Practice**
**Obstetrics and Gynecology**
**General Surgery**
**Ophthalmology**
**TO ASSOCIATE WITH**
**Radiology:**
D. H. Lonngren, M. D.
**Pathology:**
Fulvio Franyutti, M. D.
**Surgery:**
Hu C. Myers, M. D.
A. Kyle Bush, M. D.
J. W. Woodford, M. D.
**Gynecology and Obstetrics:**
Raymond W. Cronlund, M. D.
**Internal Medicine:**
E. G. Guy, M. D.
Karl J. Myers, Jr., M. D.
Wm. A. SanPablo, M. D.
C. S. Kadakia, M. D.
**Pediatrics:**
E. G. Kreider, M. D.
J. M. Nissley, M. D.
**Dentistry:**
Glenn B. Poling, D. D. S.
Contact: E. G. Kreider, M. D.
Telephone: (304) 457-2800

# County Societies

## CABELL

The Cabell County Medical Society met on April 10 at the Gateway Holiday Inn in Barboursville.

The speaker was Dr. Lewis Clayman of Huntington, a specialist in oral and maxillofacial surgery. Doctor Clayman gave a very enlightening discussion on orthognathic surgery.

Dr. Albert C. Esposito brought to the attention of the Society the bill recently passed by the State Legislature changing from a physician to a consumer majority the control of medical service (Blue Shield) corporation boards. The new law was discussed by the Society.—Charles E. Turner, M. D., Secretary.

* * *

## FAYETTE

The Fayette County Medical Society met on April 2 at Oak Hill Hospital.

The guest speaker was M. K. Hasan, M. D., Beckley psychiatrist, who gave a comprehensive talk on "Treatment of Depression by the General Practitioner."

A few minutes of silence were observed in memory of the late Dr. Ivan H. Bush, Jr., of Oak Hill, and the Society decided to make a contribution to the Ivan H. Bush, Jr., Memorial Fund.

Members of the Society agreed that the Society should make its expertise available to the Fayette County Board of Education for the planning of school health programs.—Daniel B. Doyle, M. D., Secretary.

* * *

## LOGAN

Dr. Stephen D. Ward of Wheeling, President of the State Medical Association, was guest speaker for the meeting of the Logan County Medical Society on April 9 at the Logan Country Club.

Doctor Ward spoke on the role of organized medicine and the accomplishments of the State Medical Association during the past year.

Mr. Tom Auman of Charleston, Account Supervisor for Aetna Life and Casualty, the State Medical Association's carrier for malpractice insurance, addressed the membership regarding the necessity of adequate documentation in preventing or defending potential liability suits.—Herbert D. Stern, M. D., Secretary.

* * *

## McDOWELL

The McDowell County Medical Society met on April 9 in the office of Dr. Charles F. McCord in Welch.

Dr. Ross M. Patton has become President of the Society following the resignation of Dr. Cheryl Lynn Linkous, who resigned and left the county.

Doctor McCord, an ophthalmologist, presented the medical program on injury to the eyelid, eye and orbital area.

The Society agreed to sponsor a camper for Camp Kno-Koma for diabetics.—Muthusami Kuppusami, M. D.

* * *

## MERCER

The Mercer County Medical Society met on April 21 at Frankie's LaSalute Club in Bluewell.

The guest speaker was Dr. Carl H. Bivens of Roanoke, Virginia, who gave a clear and concise presentation on thyroid disease, including diagnosis and therapy.

Dr. N. H. Dyer, West Virginia's Health Director from 1946 to 1977, was presented a plaque in recognition of his many contributions to medicine by Charles R. Lewis of Charleston, Executive Secretary of the State Medical Association. Doctor Dyer now lives in Princeton.—David F. Bell, Jr., M. D., Secretary-Treasurer.

* * *

## PARKERSBURG ACADEMY

The Parkersburg Academy of Medicine met on April 9 at the Rosemar Supper Club in Parkersburg.

Edward D. Freis, M. D., Professor of Medicine at Georgetown University, was guest speaker. His topic was "What's New in Hypertension?."

The Society approved a donation of $100 to the Society for the Prevention of Blindness as a memorial to the late Dr. Edward Shupala of Parkersburg, an ophthalmologist.—Bill M. Atkinson, M. D., Secretary-Treasurer.

* * *

## MINGO

J. Zeb. Wright, Ph.D., of Charleston was the speaker for the meeting of the Mingo County Medical Society on April 9.

Doctor Wright is Coordinator, Continuing Education, Department of Community Medicine.

(Continued on Next Page)

COUNTY SOCIETIES—*Continued*

West Virginia University Medical Center, Charleston Division. He explained WVU's plan to bring CME programs to physicians in all parts of the State. The Society was most receptive to this.

The formation of a physician-owned insurance company for the purpose of malpractice insurance — as is being explored by the State Medical Association — was favored by the Society.—Arthur E. Levy, M. D.

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OBITUARIES—*Continued*

stillborn daughter, Kelly Marie. Mrs. Rogers was eight months' pregnant.

A native of Springfield, Missouri, Doctor Rogers was graduated from West Virginia University and received his M. D. degree from WVU School of Medicine in 1974.

After interning at the Medical University of South Carolina, he was in family practice at Fayetteville for one year. He then returned to the Medical University of South Carolina for a residency in radiology, which he completed earlier this year.

Doctor Rogers was a member of the Fayette County Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include a daughter, Jacqueline Anne Rogers, at home; the parents, Ivy and Ruth Rogers of Springfield; a brother, Russell Rogers of Kansas City, Missouri; two sisters, Mrs. Sandy Frost and Mrs. Dana Williams, both of Springfield, and the grandmothers, Mrs. Cecil Rogers and Mrs. Anna Wageman, both of Springfield.

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WVU GRADUATES—*Continued*

Neurology: Gwynne A. Marstiller, Fairmont, Monmouth Medical Center, Long Branch, N. J.; Leeman P. Maxwell, Salem, WVU Department of Internal Medicine; Mary C. Maxwell, Petersburg, WVU Department of Pediatrics; Robert B. McBride, Jr., Charleston, Charlotte (N. C.) Memorial Hospital and Medical Center; Daniel F. Miller, Charleston, Cleveland (Ohio) Clinic Foundation; Jeffrey S. Moneman, Wellsburg, WVU Department of Radiology; Samuel D. Morris, New Martinsville, Kanawha Valley Family Practice Program.

John D. Muldoon III, Salem, North Carolina Baptist Hospital, Winston-Salem; Dennis R. Niess, Wheeling, Wheeling Hospital; Joan M. Phillips, Poca, CAMC; David A. Pitrolo, Morgantown, WVU Department of Internal Medicine; W. Joseph Plymale, Huntington, CAMC; James K. Porterfield, Martinsburg, The Johns Hopkins Hospital, Baltimore; Joan G. Potter, St. Albans, North Carolina Memorial Hospital, Chapel Hill; Harold T. Reynolds, East Bank, Ohio State University Department of Physical Medicine and Rehabilitation, Columbus.

Jane W. Riester, Morgantown, WVU Department of Surgery; Howard M. Rigg III, Daniels, Cedars-Sinai Medical Center, Los Angeles; Fred S. Robertson, Keystone, Walter Reed Army Medical Center, Washington, D. C.; Robert D. Rubin, Charleston, Mount Sinai Hospital, Miami Beach; Robert A. Shirey, Lewisburg, CAMC; Michael R. Simmons, Alderson, Greater Baltimore Medical Center; Glenn R. Snider, Fairmont, and Janice C. Sobray, Wheeling, Wheeling Hospital.

Eugene W. St. Clair, Morgantown, Duke University Medical Center, Durham, N. C.; Jeffrey L. Stambough, Williamson, University of Pennsylvania Hospitals, Philadelphia; Daniel H. Stewart, Mullens, WVU Department of Surgery; Carl R. Sullivan III, Charles Town, WVU Departments of Internal Medicine and Behavioral Medicine and Psychiatry; Marc A. Swanson, Beckley, Vanderbilt University Hospital; Michael E. Taylor, Bridgeport, United Hospital Center, Clarksburg; Michael J. Taymor, Morgantown, WVU Department of Family Practice; Mark G. Wertman, Morgantown, WVU Department of Surgery.

John A. White, Glasgow, William Shands Hospital, University of Florida; Randal E. White, Gilbert, University of Kentucky Medical Center; Robert R. Whitten, Jr., Huntington, Riverside Methodist Hospital, Columbus, Ohio; Richard C. Wisman, Milton, WVU Department of Medicine and Behavioral Medicine and Psychiatry; Donza T. Worden II, Parkersburg, Mercy Hospital, Pittsburgh; Mari M. Yambor, Fairmont, St. Mary's Hospital and Medical Center, San Francisco; and Tony R. Zerb, Parkersburg, Presbyterian Hospital, University of Pittsburgh.


**Office Space Available**

Medical office space available for general practice in McMechen, West Virginia, with service extending to South Wheeling, Benwood, Glen Dale and Moundsville. Low rental, office with waiting room, secretary's alcove, four examining rooms, laboratory, two restrooms and kitchenette. W/W carpet and office furniture throughout. H/A conditioning. Plenty of free parking space, and bus stop at the door. Available immediately. Contact: George Reilly, 1113 Lincoln Street, McMechen, WV 26040. Telephone: (304) 232-7239.

## PHYSICIANS NEEDED

The Navy is seeking physicians who want an alternative to the administrative burden and expense of private practice. Our modern medical facilities provide the latest techniques and equipment. Opportunities exist to do research on projects both exciting and clinically meaningful, including aerospace and submarine medicine, underwater physiology and environmental and preventive medicine. Professional allowances in addition to competitive salaries. Non-taxable quarters and subsistence allowances. 30 days' paid vacation earned each year. Insurance, medical, dental package. For more information, contact:

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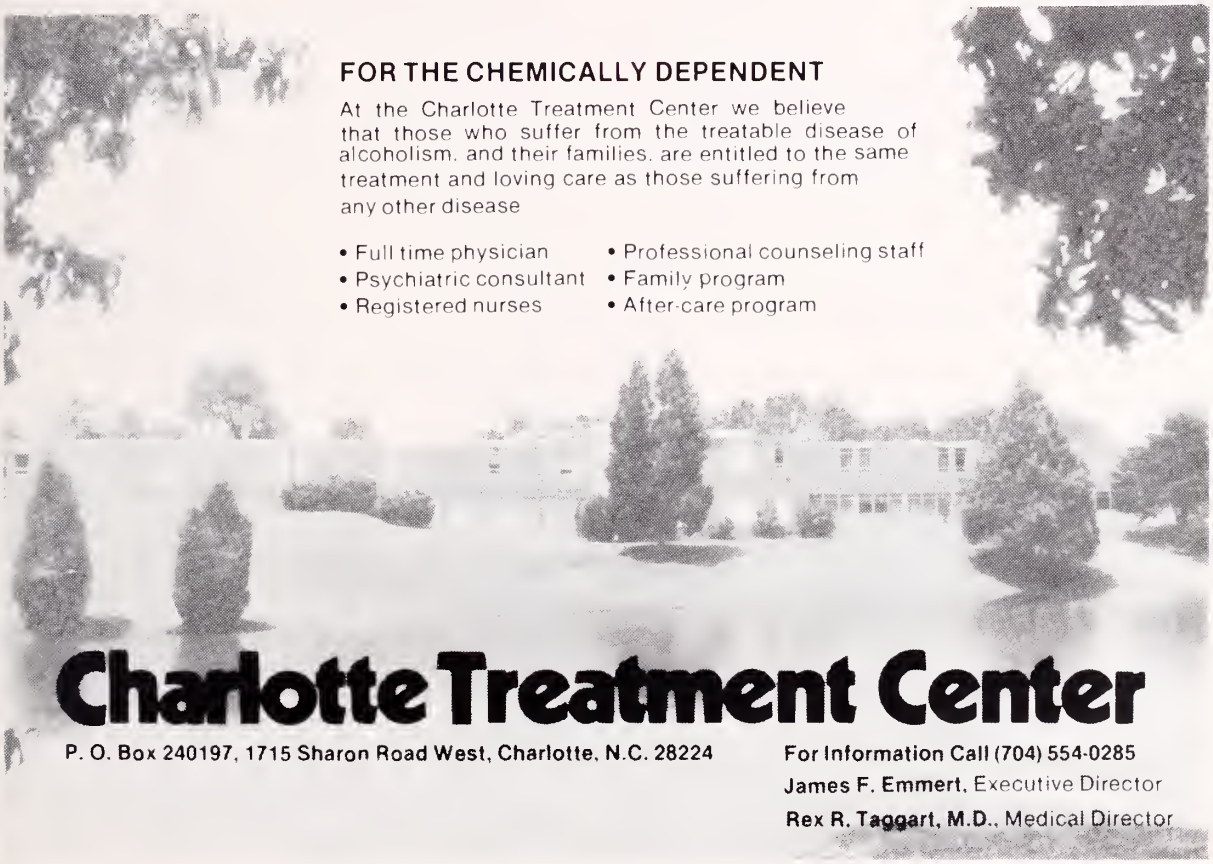

# Annual Audit, 1979

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1979 has been completed by the firm of Ernst & Whinney, Certified Public Accountants of Charleston. The completed audit, with accountants' report, follows:

ERNST & WHINNEY
716 Charleston National Plaza

To the Council
West Virginia State Medical Association
Charleston, West Virginia

We have examined the statements of assets, liabilities, and fund balances arising from cash transactions of the several funds of the West Virginia State Medical Association as of December 31, 1979, and 1978, and the related statements of revenues collected and expenses paid of the unrestricted funds and changes in fund balances of the several funds for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As described in Note A, the Association's policy is to prepare its financial statements on the basis of cash receipts and disbursements; consequently, certain revenues and the related assets are recognized when received rather than when earned, and certain expenses are recognized when paid rather than when the obligation is incurred. Accordingly, the accompanying financial statements are not intended to present financial position and results of operations in conformity with generally accepted accounting principles.

In our opinion, the aforementioned financial statements present fairly the assets, liabilities, and fund balances arising from cash transactions of the several funds of the West Virginia State Medical Association at December 31, 1979 and 1978, and the revenues collected and expenses paid of the unrestricted funds and changes in fund balances of the several funds for the years then ended, on the basis of accounting described in Note A, which basis has been consistently applied.

ERNST & WHINNEY

Charleston, West Virginia
March 24, 1980

## STATEMENTS OF ASSETS, LIABILITIES AND FUND BALANCES ARISING FROM CASH TRANSACTIONS
## WEST VIRGINIA STATE MEDICAL ASSOCIATION

| | December 31 | |
|---|---|---|
| | 1979 | 1978 |
| **UNRESTRICTED FUNDS** | | |
| ASSETS | | |
| Cash | $ 4,819 | $181,525 |
| Certificates of deposit | 169,673 | 82,314 |
| Land — Note A | 77,677 | -0- |
| Other assets | 36 | 36 |
| | $252,205 | $263,875 |
| LIABILITIES | | |
| Due to restricted funds | $ 22,573 | $ 9,375 |
| FUND BALANCES | | |
| Undesignated | 217,236 | 242,104 |
| Degignated for professional liability education | 12,396 | 12,396 |
| | 229,632 | 254,500 |
| | $252,205 | $263,875 |
| **RESTRICTED FUNDS** | | |
| ASSETS | | |
| Cash | $ -0- | $ 39,301 |
| Certificates of deposit | 52,142 | 10,102 |
| Due from unrestricted funds | 22,573 | 9,375 |
| Investment in common stock | 4,250 | 4,250 |
| | $ 78,965 | $ 63,028 |
| FUND BALANCES | | |
| Medical scholarship | $ 74,715 | $ 58,778 |
| Endowment | 4,250 | 4,250 |
| | $ 78,965 | $ 63,028 |

See notes to financial statements

## STATEMENTS OF REVENUES COLLECTED AND EXPENSES PAID—UNRESTRICTED FUNDS

| | Year Ended December 31 | |
|---|---|---|
| | 1979 | 1978 |
| REVENUES COLLECTED | | |
| Dues | $545,248 | $512,968 |
| Advertising | 21,463 | 17,875 |
| Interest | 18,910 | 19,362 |
| Contributions | 4,485 | 4,402 |
| Refund of expenses | 633 | 538 |
| Other revenues, including grants from endowment fund: 1979—$600; 1978—$552 | 12,165 | 10,726 |
| | 602,904 | 565,871 |
| EXPENSES PAID | | |
| Dues remitted to AMA | 285,313 | 272,105 |
| Salaries and wages | 103,632 | 86,096 |
| Employee benefits | 11,297 | 8,817 |
| Taxes—payroll and other | 6,203 | 4,003 |
| Office rent | 11,301 | 7,962 |
| Office supplies and expenses | 13,533 | 6,556 |
| Telephone | 4,136 | 3,986 |
| Postage | 9,125 | 10,058 |
| Travel | 39,898 | 27,563 |
| Convention speakers and supplies | 29,601 | 28,123 |
| Publishing and printing | 75,444 | 59,528 |
| Other expenses | 38,289 | 26,862 |
| | 627,772 | 541,659 |
| EXCESS (DEFICIENCY) OF REVENUES COLLECTED OVER EXPENSES PAID | $(24,868) | $ 24,212 |

See notes to financial statements

## STATEMENTS OF CHANGES IN FUND BALANCES ARISING FROM CASH TRANSACTIONS

### Year Ended December 31, 1979 and 1978

| | | RESTRICTED FUNDS | |
|---|---|---|---|
| | Unrestricted Funds | Medical Scholarship Fund | Endowment Fund |
| Balance, January 1, 1978 | $230,288 | $ 53,483 | $ 4,250 |
| Excess of revenues collected over expenses paid | 24,212 | — | — |
| Dues | | 20,988 | — |
| Interest collected | | 4,307 | — |
| Scholarships to medical students | | (20,000) | — |
| Dividends received | — | — | 552 |
| Grant to unrestricted funds | — | — | (552) |
| Balance, December 31, 1978 | 254,500 | 58,778 | 4,250 |
| Excess of expenses paid over revenues collected | (24,868) | — | — |
| Dues | — | 22,698 | — |
| Repayment of scholarships | — | 1,000 | — |
| Interest collected | — | 2,739 | — |
| Scholarships to medical students | — | (10,500) | — |
| Dividends received | — | — | 600 |
| Grant to unrestricted funds | — | — | (600) |
| Balance, December 31, 1979 | $229,632 | $ 74,715 | $ 4,250 |

See notes to financial statements

## NOTES TO FINANCIAL STATEMENTS
## WEST VIRGINIA STATE MEDICAL ASSOCIATION

### NOTE A — PRESENTATION OF FINANCIAL STATEMENTS

The financial statements are presented using the cash basis of accounting. Therefore, certain revenues and the related assets are recognized when received rather than when earned, and certain expenses are recognized when paid rather than when the obligation is incurred. Office equipment, which is not material, is charged to expense at time of purchase.

Land, which was acquired in 1979 for possible expansion purposes, is stated at cost.

The Association has designated a special assessment to be used for professional liability education. The funds are to be used to inform physicians about current and potential problems with malpractice insurance and are accounted for as unrestricted funds.

Investments received as a gift or bequest are stated at fair market value as of date of grant.

The Association provides scholarships to students attending the Schools of Medicine of West Virginia University and Marshall University for the purpose of defraying expenses incurred by students. Under certain conditions, as set forth in the scholarship agreements, the scholarships are repayable to the Association in whole or in part. Scholarships to students and repayments are recorded as decreases and increases, respectively, in the medical scholarship fund balance.

### NOTE B — LITIGATION

The Association is one of the defendants in a class action suit by a group of practitioners of Chiropractic Medicine against Blue Shield of Southern West Virginia and others. The suit alleges a violation of certain sections of the Sherman Act. The case has been scheduled for trial.


## CLINIC DIRECTOR

For the Alleghany Mental Health Clinic (Virginia), a state operated facility with a full-time staff of 5 employees and several consultants. The clinic provides general outpatient care, diagnostics, referrals, aftercare, crisis intervention, and liaison with state hospitals. Alleghany County is a rural, mountainous area, approximately 50 miles north of Roanoke (pop. 100,000). Besides a scenic landscape, there are many outdoor recreation pursuits—camping, hiking, fishing, etc. In addition to the administrative responsibilities, the director carries a patient case load; plans and directs community activities; makes case assignments and provides guidance to staff, etc. Candidates must have a Ph.D in a mental health profession; 4 years of professional experience in a mental health clinic or hospital; and the ability to evaluate and treat mental patients. Salary: $21,400-$29,300 plus excellent benefit program. Apply by June 30 to: Personnel Department of Mental Health and Mental Retardation, P. O. Box 1797, Richmond, VA 23214. EOE

# THE WHEELING CLINIC

**EOFF AT 16th STREET**

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**General Surgery:**
John O. Rankin, M. D.
Charles D. Hershey, M. D.
Edward C. Voss, M. D.

**Ophthalmology:**
William F. Park, M. D.
Milton E. Nugent, M. D.
Rizal V. Pangilinan, M. D.

**Ear, Nose & Throat:**
Wilfredo A. Tiu, M. D.

**Orthopedic Surgery:**
Edgar L. Barrett, M. D.
Richard S. Glass, M. D.

**Thoracic Surgery:**
Daniel W. Dickinson, M. D.

**Obstetrics and Gynecology:**
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.
Terry Athari, M. D.
James W. Campbell, M. D.

**Urology:**
Donald C. Trapp, M. D.
John P. Franz, M. D.

**Dermatology:**
K. William Waterson, M. D.

**Internal Medicine:**
Albert M. Valentine, M. D.
Carlos A. Vasquez, M. D.
Thomas E. Chvasta, M. D.
Byron L. VanPelt, M. D.
Paul R. Hedges, M. D.
T. Gary Kenamond, M. D.
Derrick L. Latos, M. D.
William E. Noble, M. D.
Larry R. Cain, M. D.

**Psychiatry:**
David H. Smith, M. D.
Stephen D. Ward, M. D.
David Hill, M. D.

**Neurology:**
Albert L. Wanner, M. D.
Henry L. Kettler, M. D.
Srini Govindan, M. D.

**Roentgenology:**
Drs. Butler, Aceto & Assocs.

**Speech Pathologist and Audiologist:**
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Lilly, Eli, and Company x

McDonough Caperton Shepherd Association Group xiii

Medical Search Consultants, Inc. *Insert*

Myers Clinic, The xvi

Pathology Associates Laboratory iv

Prince Medical Reference Laboratories xi

Roche Laboratories ii, iii, *Inside Back Cover, Back Cover*

Rorer, William H., Inc. *Insert*

Saint Albans Psychiatric Hospital xxiii

Schering Corporation vi, vii

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# Librium® 5mg, 10mg, 25mg capsules
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**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Warn patients that mental and or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** In the elderly and debilitated, and in children over six: limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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# The West Virginia Medical Journal

*Official Publication of the West Virginia State Medical Association*

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**MEMBER, WEST VIRGINIA PRESS ASSOCIATION, 1980**

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# CONTENTS

**Scientific Articles**

Is Intensive Care Unit Cost Effective?—A. H. Kalla, M. D.; and E. C. Voss, Jr., M. D. 151

Tuberculosis and Acute Leukemia—Erlinda L. de la Pena, M. D.; Cordell A. de la Pena, M. D.; and Vicente Anido, M. D. 159

**Scientific Department**

Medical Grand Rounds From The West Virginia University Medical Center (Asbestos-Related Diseases Of The Lung)—Edited by Irma H. Ullrich, M. D. 163

**The President's Page**

The Future—Stephen D. Ward, M. D.; President, W. Va. State Medical Association 170

**Editorials**

A New Chance For Mischief 171
Another Layer Of Bureaucracy 172
Sparks Aglow 172
PSRO—Past And Future 173

**General News**

Convention Program Includes AMA Speakers 174
WVU Medical School Faculty Promotions 175
AMA House Meets In July 177
Huntington Surgical Symposium Planned 178
88 New WVU Class Members Announced 179
Malignant Melanoma Symposium July 12 181
New MU Class Of 36 Named 181
VA Appoints MU Dean To Advisory Group 182

**Special Departments**

WVU Medical Center News xii
Third-Party News, Views, Program Concerns xiv
Obituaries xvi
County Societies xvii
Classified Section xx
Index To Advertisers xxii

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**containing perphenazine and amitriptyline HCl**

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4 mg perphenazine and 25 mg amitriptyline HCl.
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4 mg perphenazine and 10 mg amitriptyline HCl.

**CONTRAINDICATIONS:** Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression, known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

**WARNINGS:** TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

**PRECAUTIONS:** Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

**Perphenazine:** Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

**Amitriptyline:** In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

**ADVERSE REACTIONS:** Similar to those reported with either constituent alone.
**Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema, reversed epinephrine effect, hyperglycemia, endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement, hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia) and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

**Amitriptyline:** Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress; vomiting, anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling, black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female, increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness, fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

**OVERDOSAGE:** All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

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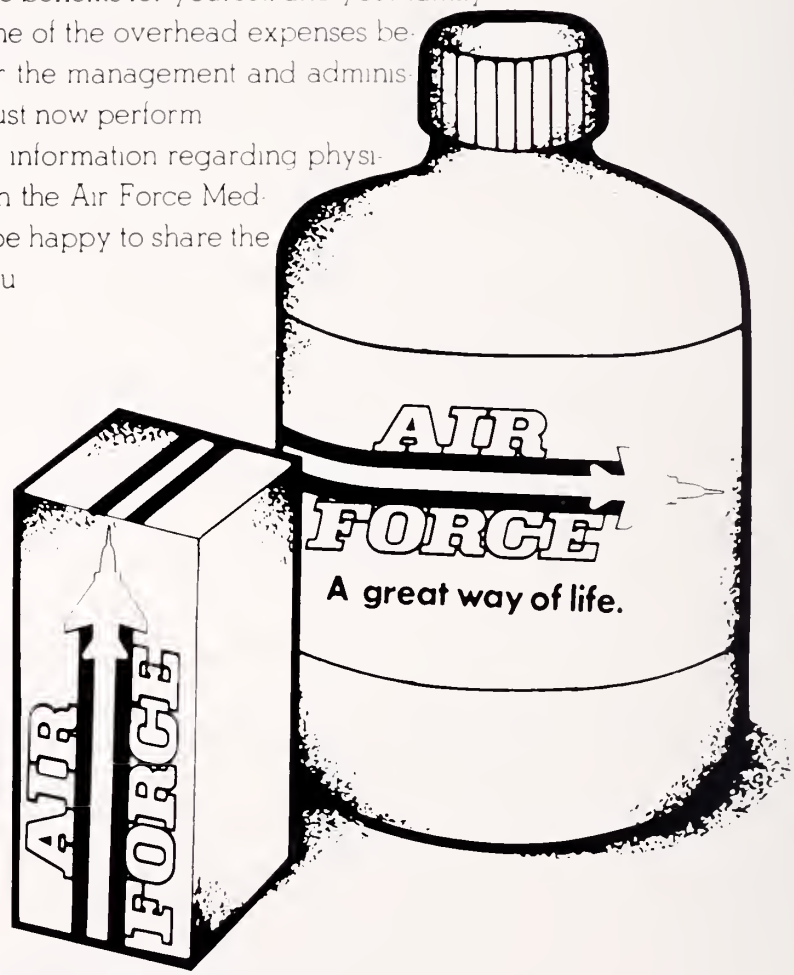


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# An added complication... in the treatment of bacterial bronchitis*

**Brief Summary.**
**Consult the package literature for prescribing information.**

**Indications and Usage:** Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

**Contraindication:** Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

**Warnings:** IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

**Precautions:** If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

*Usage in Pregnancy*—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

*Usage in Infancy*—Safety of this product for use in infants less than one month of age has not been established

**Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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**Adverse Reactions:** In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90)

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

*Hepatic*—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [070379]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

*Note* Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections including the prophylaxis of rheumatic fever. See prescribing information

**References**


1. Antimicrob. Agents Chemother., *8*:91, 1975
2. Antimicrob. Agents Chemother., *11*:470, 1977
3. Antimicrob. Agents Chemother., *13*:584, 1978
4. Antimicrob. Agents Chemother., *12*:490, 1977
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880 Washington, D.C.: American Society for Microbiology, 1978
6. Antimicrob. Agents Chemother., *13*:861, 1978
7. Data on file, Eli Lilly and Company
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979


Lilly

*Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285*

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# Is Intensive Care Unit Cost Effective?

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*In 294 consecutive critically-ill surgical patients admitted to the Intensive Care Unit (ICU), we determined survival and quality of life, hospitalization charges and consumption of blood and blood products. These patients were physiologically unstable and required intensive medical and nursing care.*

*In one month, 33 patients (11.2 per cent) had died, 150 were still in the hospital, and 111 were home. At six months, 41 (16.0 per cent) patients had died and 22 were still hospitalized; of 253 survivors, 116 (45.8 per cent) were fully recovered; 22 (8.69 per cent) maintained partial recovery; 13 (5.77 per cent) showed no improvement and 47 (18.57 per cent) were lost to follow-up. Total ICU hospitalization charges were $4,955,630 and total blood and component charges were $293,088.5. The average ICU charge per patient was $15,101; per survivor, $18,637. The average blood and component charges per survivor, and for 80 per cent of the non-survivors, were five per cent of the patient's total bill. The same charges for the remaining 20 per cent of non-survivors were 25 per cent of the patient's total bill.*

*During this same time period, the average daily charge for all hospital patients was $252. The average daily ICU charge was $617.*

*Major system complications were: Respiratory, 38.09 per cent; Renal, 9.18 per cent, and Cardiac, 8.10 per cent. Of 33 deaths, nine autopsies were done.*

In our present, imperfect world there is still much sickness. Everyone agrees that care of the sick, euphemistically called "health care," is a right to which all citizens should have equal access without financial or social barriers. However, in the United States, the total cost of health care, both private and public, was $142 billion in 1977 and $163 billion in 1978, or nine per cent of the Gross National Product and 15 per cent of the American family income. Between 1940-1972, health care expenditures per capita increased 14 times in absolute dollars and fourfold in constant dollars.

Intensive care has become a household word in American medicine within the past two decades. Although initially designed to reduce mortality in single-organ failure, intensive care units (ICUs) now help salvage patients with multiple-organ failure. Initially conceived and implemented in large referral centers, the concept has now been adopted in the smallest community hospitals.

During the period ICUs have been in use, they have contributed significantly to the awesome growth of hospital costs. This has led us to make a critical examination of results attained through this enormous expenditure of money and manpower.

The purpose of this paper is to review some selected aspects of the cost-benefit ratio in an ICU, using data available from a teaching, community medical center (a 500-bed hospital offering approved residencies in general surgery, internal medicine, obstetrics-gynecology, pathology and radiology).

### History of ICU

Our multidisciplinary ICU was opened in 1963. The current 14-bed unit, with an average of 260 square feet per patient, fulfills the basic and current concepts in design criteria. Monitoring is alarm-oriented, and physiological variables are continuously displayed at each bedside site.

The unit is under the guidance of the Medical Staff ICU Committee, the members of which ro-

tate. Admission to the unit is by order of the attending physician. The purpose basically is to provide continuous monitoring and support of vital physiological systems and to prevent a critical state from developing. There are no age criteria.

A most important factor in providing full patient care is the provision of a fully-trained, experienced nursing staff. The aim is to provide one fully-trained registered nurse per room at all times, augmented by the ancillary personnel.[5,14,17] Continuing education is emphasized.

Analysis of admission habits indicates that patients are admitted whether or not their condition seems potentially reversible. Ethical and moral problems regarding maintenance of life support, once an irreversible situation develops, are resolved only by the attending physician and the patient's family.

Admissions to the unit were classified as either medical or surgical. During this period (January-December, 1978), 796 patients were admitted: 496 (62.3 per cent) medical and 300 (37.7 per cent) surgical.

### Definition of ICU

An intensive care unit should be designed to manage patients with immediate, acute but potentially *reversible* life-threatening impairment of single or multiple-organ systems. It also should aim at prophylaxis of such catastrophes as cardiac arrest, respiratory arrest, shock, renal failure, or overwhelming sepsis. The unit must be organized with a concentration of specialized personnel, techniques, and equipment to provide continuous surveillance and coordinated care of potentially salvageable patients. It is not a substitute for an emergency room, which receives and distributes patients with a wider variety of illnesses of differing severities, nor for a recovery room, which focuses on postoperative prophylaxis (although it can be combined with one), nor for a terminal care unit, which is designed for those whose medical course cannot be reversed by any known therapy.

### Admission Policies and Practice

Although patients are admitted under, and remain the responsibility of, the attending staff, the intensive care staff cooperate in the complete management and support of all physiological systems.

The function of the ICU Committee is to formulate general policy regarding admission, treatment and discharge, and to monitor implementation of that policy.

ICU criteria for admission are: (1) acutely-ill patients, admitted either through the emergency room or transferred from other departments or other hospitals, and (2) postoperative, regardless of age or disease.

The complexity of multiple-system disorders necessitates detailed patient documentation both on admission and on each day thereafter. These notations are charted or recorded on flow sheets on an open grid display. The provision of print-out data from the hospital's laboratory computer permits immediate availability of results and retrieval of relevant data prior to admission to the unit, if needed.[5,17]

### Definition of Patient Population and Methods of Analysis [5,10,11,14,16,17]

The evaluation of critical illness too often depends upon observers' opinions. Two approaches for evaluation exist. The first is consideration of the disease process and its complications. The drawback here is that this does not distinguish between patients with single-system disease and those with multiple-organ failure.

The second approach is to define the severity of illness, regardless of disease process, assuming that the pathophysiology of organ dysfunction follows common paths that require standard interventions. By quantitating therapeutic interventions one can more clearly define the severity of illness; for regardless of diagnosis, the more critically ill the patient, the more therapeutic interventions are needed. In any event, we have adopted the second approach, namely Therapeutic Intervention Scoring System (TISS) (Table 1).

**TABLE 1**

**Therapeutic Intervention Scoring System**

*4 Points*

a. Cardiac arrest and/or countershock within 48 hours
b. Controlled ventilation with or without PEEP
c. Controlled ventilation with intermittent or continuous muscle relaxants
d. Balloon tamponade of varices
e. Continuous arterial infusion
f. Pulmonary artery line
g. Arterial or ventricular pacing
h. Hemodialysis in unstable patient
i. Peritoneal dialysis
j. Induced hypothermia
k. Pressure activated blood infusion.
l. G-suit
m. Measurement of cardiac output
n. Platelet transfusions
o. IABA (intra-aortic balloon assist)
p. Membrane oxygenation
q. Emergency operative procedures (within 24 hours)
r. Lavage of acute G.I. bleeding
s. Emergency endoscopy or bronchoscopy

*3 Points*

a. Hyperalimentation or renal failure fluid
b. Pacemaker on standby
c. Chest tubes
d. Assisted respiration
e. Spontaneous PEEP
f. Concentrated K drip (>60 MEQ/1)
g. Nasotracheal or orotracheal intubation
h. Endotracheal suctioning (non-intubated patient)
i. Complex metabolic balance (frequent intake and output, Brookline scale)
j. Multiple ABG, bleeding and STAT studies
k. Frequent infusions of blood products
l. Bolus iv medication
m. Multiple (>3) parenteral lines
n. Vasoactive drug infusion
o. Continued antiarrhythmia infusions
p. Cardioversion
q. Hypothermia blanket
r. Peripheral arterial line
s. Acute digitalization
t. Active diuresis for fluid overload or cerebral edema
u. Active Rx for metabolic alkalosis or acidosis
v. Emergency thora-, para- and peri-cardio-centeses
w. Acute anticoagulation
x. Phlebotomy (include with active diuresis)
y. Coverage with more than two iv antibiotics
z. Rx of seizures or metalobic encephalopathy (within 48 hours of onset)

*2 Points*

a. CVP (central venous pressure)
b. Two iv lines
c. Hemodialysis for chronic renal failure
d. Fresh tracheostomy (less than 48 hours)
e. Spontaneous respiration via endotracheal tube or tracheostomy
f. Tracheostomy care
g. Replacement of excess fluid loss
h. Chemotherapy pump

*1 Point*

a. ECG monitoring
b. Hourly vital signs or neurovital signs
c. "Keep open" iv route
d. Chronic anticoagulation
e. Standard intake and output
f. Frequent STAT chems
g. Intermittent iv medications
h. Multiple dressing changes
i. Complicated orthopedic traction
j. IV antimetabolite therapy
k. Decubitus ulcer treatment
l. Urinary catheter
m. Supplemental oxygen (nasal or mask)
n. Antibiotics iv
o. Chest physiotherapy, IPPB
p. Extensive irrigations, packings or debridement of wound, fistula or colostomy
q. Gastrointestinal decompression

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Accordingly, we classified the ICU population into four classes or groups:

*Class I:* Postoperative R.R. patient — non-intensive care patient (excluded from this study).

*Class II:* Physiologically stable. These are merely being monitored and closely observed for a potential catastrophe. (Example: Craniotomy).

*Class III:* Physiologically stable, yet requiring intensive nursing care and invasive monitoring. (Example: Elective abdominal vascular surgery).

*Class IV*: The most critically-ill patients. These are physiologically unstable and require intensive nursing and physician care, i.e., repeated observations and changes of orders. (Example: Ruptured aortic aneurysms or severe multiple trauma).

To define the severity of illness in ICU patients objectively, we used measurable, objective data points as indicated below. The objective indicators were recorded retrospectively as follows: The value on admission to the unit and the lowest (or highest) level within the ICU:

1. Arterial $PO_2$ (spontaneous or controlled ventilation)
2. Platelet count
3. BUN
4. Creatinine
5. Other factors indicative of critical illness:
   (1) Acute renal failure and the need for dialysis (peritoneal or hemodialysis)
   (2) Antiarrhythmic therapy
   (3) A base deficit greater than 10 MEQ/1
   (4) State of consciousness (awake, responsive, obtunded or comatose)
   (5) Unexpected cardiac arrest

The patients were also divided into eight categories of Pathological Processes:

1. Elective operation for neoplastic disease
2. Massive trauma
3. Neurosurgery and head trauma
4. Emergency major vascular operations
5. Elective major vascular operations
6. Complications of elective operations (intra and postoperative)
7. Gastrointestinal bleeding
8. Emergency abdominal catastrophies without bleeding

**Results**

Table 2 shows overall hospital mortality figures over a six-year period. Table 3, for comparative purposes, shows mortality figures for the initial 30-day period following admission to the ICU. Overall ICU mortaility figures were generally more than 10 per cent. This, of course. is a reflection of the severity of illness of those admitted.

Three hundred, nineteen patients were admitted to ICU for Routine R.R. (Table 4). As noted above, these were placed in Class I and were not included in the study.

Two hundred, ninety-four patients were admitted (six were excluded as repeat admissions) either via the emergency room, transferred from other departments or postoperatively. Average age was 56 years. Average LOS on ICU was 12 days. Within one month. 33 patients (11.22 per cent) had died. This figure increased to 41 patients (13.9 per cent) at six months. A certain pattern of information appears when comparing a mortality rate of 0.68 per cent (one patient) in Class II (147 — 50 per cent) and 23.2 per cent (29 patients) in Class IV (125 — 42.5 per cent) during a one-month period (Table 4).

As shown in Table 5, of 27 patients electively operated on for neoplastic disease, eight (29.6 per cent) died within a six-month period. Ten per cent of the patients who suffered severe, massive multiple trauma and neurological deficit (Categories II and III) died. while the remainder progressed to recovery. Critically-ill patients after emergency major vascular surgery fared better than those subjected to elective major vascular surgery (six months' survival 75 per cent and 57 per cent respectively).

The entire hospitalization charges for these 294 patients were $4.955,630; total blood charges, $293.088.5. The average ICU cost per survivor in Category VI (complication of abdominal surgery) was $26.512.50; for Category III (neurosurgery and head trauma), $9,634.90.

Major complications while in ICU were: respiratory, 38 per cent; renal, 9.18 per cent, and cardiac, 8.16 per cent (Table 6).

The effect of age (Table 7), in general, showed younger patients had lower TISS points. and that those who survived the first month continued to do well. The elderly group accumulated the highest TISS points. They also had more systemic complications and had a correspondingly higher mortality rate. Among survivors. 116 patients (45.8 per cent) had a complete recovery; 22 patients (8.69 per cent) made no improvement. and 47 patients (18.57 per cent) were lost to follow-up (Table 8).

Actual hospital average charges to the ICU patient per day were $617: 55 per cent was for

**TABLE 2**

**Hospital Admissions and Mortality Rate on General Medical and Surgical Floors (1973-1978)**

| | *Admissions* | | | *Mortality Rate* | | |
|---|---|---|---|---|---|---|
| *Year* | *Total* | *Surgical* | *Medical* | *Surgical* | *Medical* | *Total* |
| 1973 | 6049 | 2458 | 3591 | 63 (2.5%) | 54 (1.5%) | 117 (1.9%) |
| 1974 | 6040 | 2461 | 3579 | 53 (2.1%) | 51 (1.4%) | 104 (1.7%) |
| 1975 | 5983 | 2437 | 3546 | 73 (2.9%) | 64 (1.8%) | 137 (2.2%) |
| 1976 | 6033 | 2450 | 3583 | 68 (2.7%) | 49 (1.3%) | 117 (2.9%) |
| 1977 | 6021 | 2470 | 3551 | 71 (2.8%) | 50 (1.4%) | 121 (2.0%) |
| 1978 | 5980 | 2410 | 3570 | 67 (2.7%) | 55 (1.5%) | 122 (2.0%) |

**TABLE 3**

**ICU Admissions and Mortality Rate, 1973-1978 (First 30 Days or Less of Each ICU Admission)**

| | | | | | | *Mortality Rate—1 Mo.* | | | |
|---|---|---|---|---|---|---|---|---|---|
| *Year* | *Total Admissions* | *Medical* | *%* | *Surgical* | *%* | *Medical* | *%* | *Surgical* | *%* |
| 1973 | 608 | 326 | (53.6) | 282 | (46.4) | 47 | (14.4) | 11 | ( 9.5) |
| 1974 | 627 | 292 | (46.5) | 335 | (53.5) | 335 | (25.3) | 38 | (17.8) |
| 1975 | 925 | 579 | (62.5) | 346 | (37.5) | 83 | (14.3) | 43 | (13.6) |
| 1976 | 865 | 527 | (50.9) | 338 | (39.1) | 63 | (11.9) | 47 | (12.7) |
| 1977 | 815 | 502 | (61.5) | 313 | (38.5) | 67 | (11.8) | 37 | (12.7) |
| 1978 | 796 | 496 | (62.3) | 300 | (27.7) | 60 | (12.0) | 33 | (11.6) |

medical and surgical supplies, 13.2 per cent for room and board, and five per cent for blood and blood products.

In a retrospective analysis of data, three groups emerged. Patients in the first group died within the first month. The second group was comprised of those who survived and went on to full recovery. Patients in the third group recovered partially or died between the first and sixth month.

**Discussion** [2,3,4,7,9,11,12,14,17]

Today it is possible to institute multisystems life support rapidly in the critically-ill patient. The question of cost effectiveness of such facilities and the philosophy behind their usage has been challenged by many critics.

The purpose of this paper was to review selected aspects of cost-benefit issues in the ICU by using data obtained in a prospective study from January 1 to December 31, 1978. Although inputs to ICU — money, manpower and space — can be measured with ease, the difficulty of evaluating outcomes is well recognized.

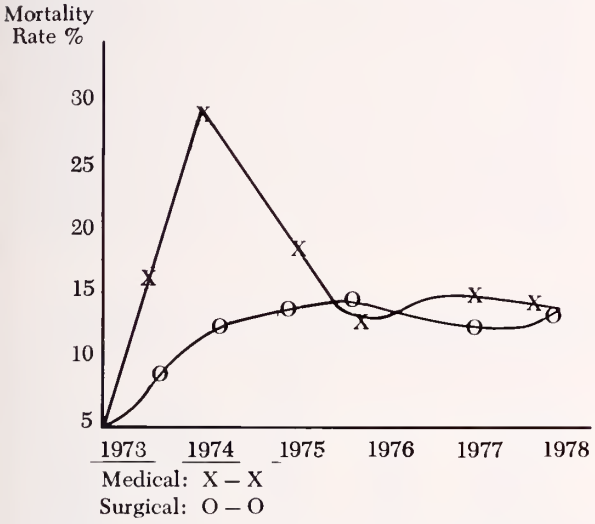


**Figure. Five-year mortality rate. Regular medical-surgical patients in ICU.**

ICU: COSTS = INPUTS VS. BENEFITS = OUTPUT

| *Inputs* | *Output* |
|---|---|
| Money | Patient Care |
| Manpower | Education |
| Space | Research |

Does the creation of an ICU reduce the cost of running a conventional hospital floor? This problem can be examined by comparing staffing requirements for a floor before and after introduction of an ICU since staff salaries make up the bulk of direct costs. In our hospital, there has been no reduction in the floor staff. Although overhead and ancillary service costs have been reduced by admission of the most critically-ill patients to ICU, the net reduction in regular floor operating costs is probably small.

In a community, teaching hospital like ours, what conditions are best treated in an ICU? To answer this question definitively, we probably need documented unsatisfactory-outcome data for a particular disease or illness treated in a conventional floor and compare this with improved-outcome data for the same disease treated in ICU. Such comparative studies, however, are not available. The decision for admission to ICU is necessarily an intuitive one, and complexity of disorders may not be easily recognized at the time of admission. Such studies are important not only for identifying groups of patients most suitable for ICU and for providing a basis of comparison against which the impact of ICU can

**TABLE 4**

**Total Number of ICU Admissions and Classifications Characteristic of ICU Population: January 1-December 31, 1978**

| *Class* | *Number of Patients* | *TISS* | *Mortality Rate* 1 Month | *Mortality Rate* 6 Months |
|---|---|---|---|---|
| Class I : Routine R.R. | °319 | --- | --- | --- |
| Class II : Close Observation | 147 (50%) | 26 | 1 ( 0.68%) | 0 |
| Class III: Intensive Nursing Care | 22 (7.4%) | 39 | 3 (13.6 %) | 5 (22.7%) |
| Class IV: Intensive Physician and Nursing Care | 125 (42.5%) | 130 | 29 (23.2 %) | 36 (28.8%) |
| TOTAL | °°294 | --- | 33 (11.22%) | 41 (13.9%) |

°Class I patients are excluded from this study.
°°6 repeat admissions for the same patients were not included.

be measured, but also for defining the extent to which ICU can benefit patients with selected conditions.

A critical assessment of the benefit of ICU also should include educational benefits given to the new generation of physicians and nurses who share in the management of patients with life-threatening situations, and whose clinical research done there leads to advances in health care of all patients. Although the costs of ICU are easily measured, the evaluation of benefits is infinitely more difficult.

Medical care assets are finite and subject to pressures from all sides. The question arises, is ICU justified? Criticisms are plentiful and so are questions. Does concentrating the elite of professional nursing staff in one unit affect the quality of care on other floors? Does it lower the efficiency of nursing staff on other floors by concentrating all critically-ill patients on ICU? Are ICU patients depersonalized by 24-hour surveillance and monitoring equipment? Are ICU patients subjected to increased risks, e.g., nosocomial infections? The figures given suggest impressive therapeutic benefits, particularly for Class II patients and those salvaged from Class IV.

How, in the future, can we control the costs? Two options are apparent: (1) set admission criteria to screen out inappropriate cases, and (2) set criteria for qualification of ICU patients whose prognosis becomes hopeless. Both options present practicalities difficult to surmount. Other cost containment measures involve setting standards for optimal care and the rational use of laboratory, radiology and disposable equipment.

Problems of social and emotional costs to family were not studied. Five patients in this group developed ICU-psychosis.

Ethical problems remain a twilight zone in many weighty ICU decisions.

The right to a chance at survival cannot be lightly over-ridden by others. This right figures importantly in those ICU situations in which there is a chance to extend life a limited time for a hopelessly or terminally-ill patient. Situations in which there is a strong possibility of creating a devastating and irreversible mental or physical impairment must be faced painfully often. Any decision made in such situations can be considered controversial. In the final analysis, the decision to go all out therapeutically or to bow to inevitable death belongs to the patient himself.

**TABLE 5**

**Categories of ICU Patients, January 1-December 31, 1978**

| *Category* | *Number of Patients* | *Average No. of Stay/Days* | *Average Age* | *Average TISS* | *Survival 6 Months* | *Average Total Cost of Hospitalization, 1 Patient* | *Total Cost of Hospitalization of all Patients* | *Charges for Blood & Blood Products, 1 Patient* | *Total Charges, Blood & Blood Products, All Patients* | *Cost to Achieve 1 Survivor—6 Mos.* |
|---|---|---|---|---|---|---|---|---|---|---|
| Elective operation for neoplastic disease I | 27 ( 9.1%) | 11 | 65 | 54 | 19 (70.3 %) | $15,200 | $ 405,000 | $ 760 | $20,520 | $21,600 |
| Massive Trauma II | 89 (30.2%) | 13.4 | 52.2 | 99 | 85 (95.5 %) | 21,500 | 1,913,500 | 1,075 | 95,075 | 22,511.76 |
| Neurosurgery and head trauma III | 55 (18.7%) | 9 | 42 | 38 | 50 (90.9 %) | 8,759 | 481,745 | 437.95 | 24,087.75 | 9,634.9 |
| Emergency Major vascular operation IV | 16 ( 5.4%) | 10 | 56.8 | 53 | 12 (75 %) | 14,000 | 22,400 | 700 | 11,200 | 18,666.66 |
| Elective Major vascular operation V | 14 ( 4.7%) | 9.4 | 70 | 51 | 8 (57.1 %) | 7,670 | 107,380 | 383.5 | 5,309 | 13,422.5 |
| Complications of elective operations (Intra & Post) VI | 50 (17 %) | 20 | 57.3 | 61 | 44 (88 %) | 23,331 | 1,166,550 | 1,166.5 | 58,325 | 26,512.5 |
| G. I. Bleeding, cirrhosis. Portal hypertension VII | 22 ( 7.4%) | 13 | 49 | 53 | 19 (86.3 %) | 20,000 | 440,000 | 1,000 | 22,000 | 23,157.89 |
| Emergency abdominal catastrophies w/o bleeding VII | 21 ( 7.4%) | 10.4 | 54.7 | 73 | 16 (76.19%) | 10,355.5 | 217,455 | 517 | 10,872.55 | 13,590.93 |

Survivors 253
Non-Survivors 41 ($605,156) Total Cost of Hospitalization & ($30,257.8) Total Charges for Blood and Blood Products
Total 294 ($4,955,630) Total Cost of Hospitalization & ($293,088.5) Total Charges for Blood and Blood Products

A strong case can be made for ICU if it is clear that guidelines are set within a general ethical framework that takes account of basic human rights. There is an obligation to ensure that in no case the only right that remains to ICU patients is the right to utilize medical technology.

### Conclusion

Modern medical knowledge and technology have over the past 25 years enabled the physician to support artificially the functions of essential organs. It is possible now, in some cases, to postpone legal death in many patients. It must be recognized that death is inevitable. We must address ourselves to the problem of finding ways of foreseeing who might benefit in a real way from organ support and who might suffer. Given the advances made and resources available we must be prepared to "pull out all stops" for the patient who can be returned to a full and useful life, but we must not be guilty of prolonging death in a patient whose time has come.

Increasing demand for very costly and very limited medical resources mandates some effort at control of utilization of these resources.

**TABLE 6**
**Major System Complications in ICU/1 Month**

| *Systems* | *No. of Patients* | *%* |
|---|---|---|
| Cardiac | 24 | 8.16 |
| Shock | 8 | 2.72 |
| Respiratory | 112 | 38.09 |
| Electrolyte/Metabolic | 19 | 6.46 |
| Renal | 27 | 9.18 |
| G. I. Bleeding | 17 | 5.78 |
| Septic | 6 | 2.04 |
| CNS - Psychosis | 5 | 1.70 |

**TABLE 7**
**Indicators of Intensive Care Comparing Survivors With Non-Survivors, 1-Month Period**

| | *Survivors* | *Non-Survivors* |
|---|---|---|
| Number of Patients | 261 | 33 |
| Average Age (years) | 52 | 64 |
| TISS points | 50 | 84 |
| Admission $PaO_2$ (torr) | 88 | 76.6 |
| Worst $PaO_2$ (torr) | 72 | 54.3 |
| Admission Platelet count ($X10^3$) | 370 | 290 |
| Worst Platelet count ($X10^3$) | 240 | 5 |
| Admission BUN (mg/100 ml) | 16 | 32 |
| Worst BUN (mg/100ml) | 31 | 62 |
| Admission Creatinine (mg/100 ml) | 1.4 | 3.2 |
| Worst Creatinine | 3.8 | 7.7 |
| Development of acute renal failure | 16 (6.1%) | 11 (33.3%) |
| Antiarrhythmia therapy | 25 (9.5%) | 10 (30.3%) |
| Base deficit greater than 10 MEQ/1 | 12 (4.5%) | 13 (39.3%) |
| State of Consciousness: | | |
| Awake | 242 (92.7%) | 22 (66.6%) |
| Obtunded | 11 (4.2%) | 6 (18.1%) |
| Comatose | 8 (3.0%) | 5 (15.1%) |

**TABLE 8**
**Patient's Condition after 6 Months of Follow-up.**

| *Condition of Patient* | *Number* | *%* |
|---|---|---|
| 1. Fully Recovered | 116 | 45.8 % |
| 2. Progress to Recovery | 55 | 21.73% |
| 3. Partial Recovery at best | 22 | 8.69% |
| 4. No Improvement | 13 | 5.77% |
| 5. Lost to Follow-up | 47 | 18.57% |
| 6. Died | 41 | 16.20% |

**TABLE 9**
**Actual Average ICU Charges as Billed for Patient**

| *(Itemized Charges)* | *%* |
|---|---|
| Medical & Surgical Supplies | 55.4 |
| Room & Board | 13.2 |
| Cardiac Care (Monitoring, Etc.) | 6.2 |
| Blood & Its Products | 5.00 |
| Operating Room | 4.4 |
| Laboratory | 4.2 |
| X-ray | 3.4 |
| Anesthesia | 3.3 |
| Pharmacy | 3.00 |
| Special Services | 1.8 |
| Total | 100 |

**TABLE 10**
**Daily Basic Charges per Surgical Patients in ICU**

| 14-Bed ICU Daily Cost: | ($) | % |
|---|---|---|
| Personnel: | $2156.45 | 38.79 |
| Supplies: | $3401.60 | 61.19 |
| | $5558.05 | |
| Per Bed: | $ 397.00 | |
| Per Patient: | $ 617.00 | |
| Occupancy Average: | 65% | |

The following are suggested as a beginning for this task:

1. Establish criteria for appropriate use of ICU.
2. Establish an intermediate-care unit for Class II patients or Category III — neurosurgery-head trauma. This unit could be used for overnight postoperative care as well.
3. Institute timely consultation with family members in regard to the advisability and desirability of measures such as CPR.
4. Organization of a separate department for terminal cases using the hospice concept as a model.
5. Organization of a medical-surgical ICU review committee, the purpose of which is to review the appropriateness of ICU admissions and continued stays.
6. Careful monitoring of use of blood and blood products.

### Summary

Because the demand for medical care is infinite, but resources finite, some form of rationing is inevitable.—Enoch Powell, Editor, Critic American National.

### Acknowledgement

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### References

1. Phillips GD: Life support, systems in intensive care: A review of history, ethics, costs, benefits and rational use. *Anesthesia and Intensive Care* 5:5,251, 1977.

2. Griner PE: Medical intensive care in the teaching hospital: Cost versus benefits. *Ann Intern Med* 78:581-585, 1973.

3. Morgan A: Dollar and human costs of intensive care: *J Scientific Research* 14:441-448, 1973.

4. Lachs J: Humane treatment and the treatment of humans. *N Engl J Med* 839:294-315, 1977.

5. McCleave DJ: The role and function of an antralian intensive care unit. *Critical Care Med* Vol. 5, No 5, 1977.

6. Leibel R: Thanatology and medical economics. *N Engl J Med* Vol 296, No 9, March, 1977.

7. Civetta J: The inverse relationship between cost and survival: *J Scientific Research* 14:265-296, 1973.

8. Del Guercio L: Triage in cold blood. *Critical Care Med* Vol 5, No 4, 1977.

9. Confronting the decision to let death come. *Critical Care Med* Vol 2, No 3, 1974.

10. Silverman D: The therapeutic intervention scoring system. An application to acutely ill cancer patients. *Critical Care Med* Vol 3, No 6, 1975.

11. Cullen D: Results and costs of intensive care. *Anesthesiol* 47:203-216, 1977.

12. Cohen C: Ethical problems of intensive care. *Anesthesiol* 47:217-227, 1977.

13. Mustard R: The cost of health. *Surg* Vol 80, No 3, 1976.

14. Cullen D: Survival, hospitalization charges and followup results in critically ill patients. *N Engl J Med* Vol 294, No 18, April, 1977.

15. *JAMA* April 13, 1979.

# Tuberculosis And Acute Leukemia

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*Both tubercle bacilli infections and acute myelomonocytic leukemias cause significant peripheral blood monocytosis. Whether the two entities are present together or that only one is the disease entity present should be determined correctly in order to institute proper therapy. The determining factors are: pancytopenia with significant thrombocytopenia; the presence of Auer rods; the response to anti-TB drugs; and the presence of leukemic infiltrates in visceral organs.*

THIS is the case of a 54-year-old white male who was admitted to the Veterans Administration Medical Center, Clarksburg, West Virginia, for continuation of treatment for tuberculosis and aplastic anemia. The patient was transferred to this hospital from the United Hospital Center, Inc., Clarksburg, where he was admitted for anemia, leukopenia and "a nodular lesion" of the left chest. At that hospital, studies showed acid-fast micro-organisms in his sputum and urine. Subsequent culture studies were consistent with tubercle bacilli. The patient was started on isoniazid, rifampin and ethambutanol. Because he was a veteran, he was transferred to this hospital.

On admission, the patient complained of marked weakness, and was extremely pale with a spiking temperature of 104°F. The pulse rate was 136 per minute; blood pressure, 120/68 mm., and respirations, 26 per minute. Small indurated ulcers measuring no more than one half cm. each were present on the mucosa of the buccal cavity. Examination of the heart and lungs showed no significant alterations. There was no evidence of lymphadenopathy in the neck, axilla or groins. The liver was noted to be enlarged two finger breadths below the right costal margin. There was a three-centimeter decubitus ulcer in the left buttock. Neurological examination was essentially unremarkable.

Laboratory examination showed a white count of 7.8 x $10^9$/1 (7,800/ul), a red count of 1.8 x $10^{12}$/1 (1,800,000/ul), a hemoglobin of 7.5 gm/dl, and a hematocrit of 17.6 per cent. The MCV was 91 fl; MCH, 29.4 pcg, and MCHC, 32.4 per cent. The differential white cell peripheral study showed 40 per cent blastic cells, two bands 20 monocytes and 38 per cent polyps. EM studies showed the monocytes were atypical, and many showed nucleolar and nuclear membrane chromatin condensation (Figure 1). The reticulocyte count was two per cent. The sedimentation rate was rapid at 128 mm./one hr. The platelet count was .0087 x $10^{12}$/1 (8,700 ul); bleeding time, two min., 45 sec.; PTT 37 sec. with a control of 33; and prothrombin time, 15.2 sec. with a control of 12. Blood chemistries were unrevealing.

The bone marrow aspirate showed marked preponderance of myelomonoblasts which represented 56 per cent of the total nucleated hematopoietic elements. Auer rods were seen (Figure 2). The overall picture of the bone marrow was consistent with a maturation arrest associated with a typical leukemic hiatus. Megakarocytes were few. Electron microscopy studies of the bone marrow showed distinctive, ultrastructural configuration patterns consisting of nuclear folding and irregularity with deep indentation and scant intranuclear chromatin. The mitochondria were considered larger than usual. Azurophilic granules were considered larger than usual but were fewer. Some of the myelomonocytic cells showed only scanty chromatin condensation of the nuclear borders, and nucleoli were prominent (Figures 3 and 4). The diagnosis of acute myelomonocytic leukemia with pulmonary and urinary tract tuberculosis was made. Therapy was considered; however, it was decided that the patient should be transferred to the VA Medical Center, Pittsburgh, Pennsylvania. Shortly after being admitted there, the patient expired. Postmortem examination was not granted.

### Discussion

The apparent coincidence of leukemia and various infections, principally tuberculosis, was first noted by various observers, mostly in Ger-

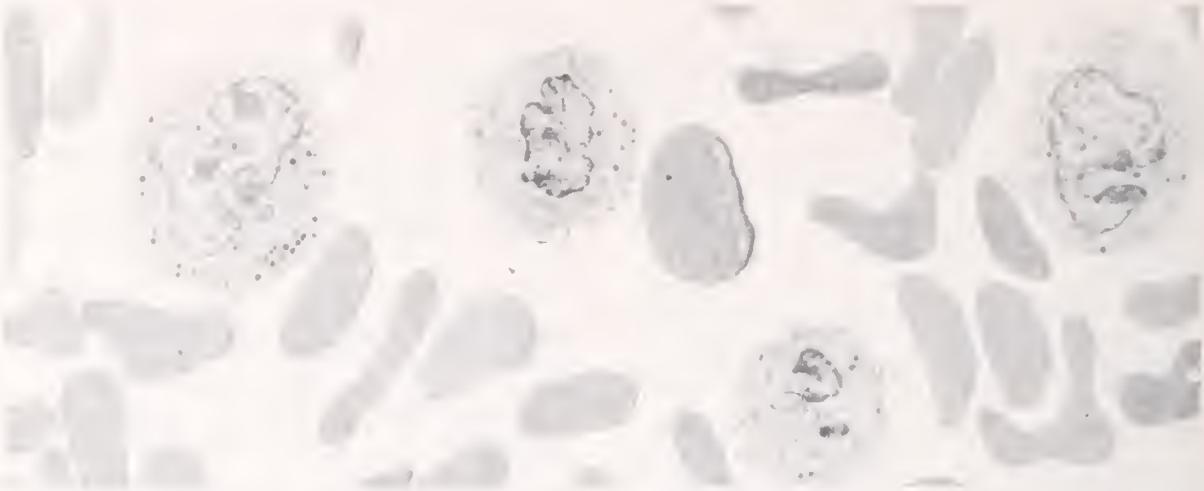

**Figure 1. EM peripheral blood shows atypical monocytoid cells in peripheral blood with nuclear and nucleolar condensation at the nuclear membrane. Note convoluted and infolded nuclear shapes.**

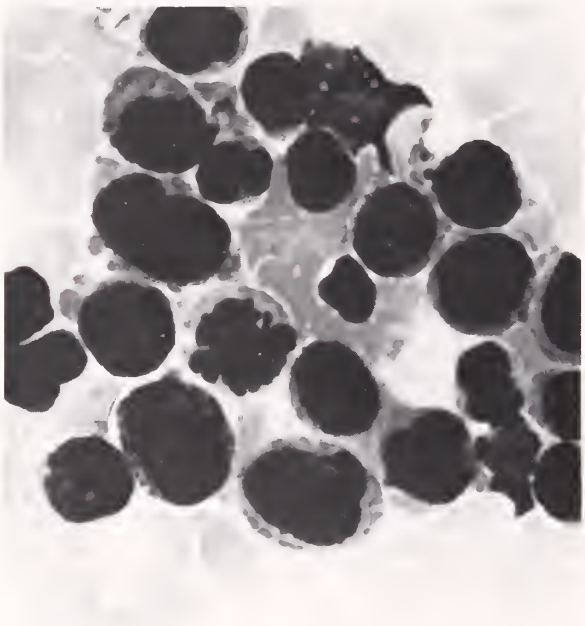

**Figure 2. Bone marrow—oil immersion showing immature, atypical myelomonocytes; note "Auer rod."**

man literature, as early as the ninth century.[1] Because bone marrow aspiration or biopsy as a diagnostic tool was not as yet, in general, used, many of these cases were categorized as leukemoid reactions due to the tuberculosis.[2] It was found later that many of these so-called cases were indeed leukemia since autopsies later showed definite leukemic infiltration of the visceral organs and arrest of maturation of the myelomonocytic cells in the bone marrow.[3,4,5]

A genuine combination of tuberculosis and leukemia is not uncommon, though probably no greater than expected from chance association. There are cases in contrast to those mentioned above which showed leukemic changes in the peripheral blood and bone marrow but at autopsy showed no leukemic infiltration in the visceral organs; instead, they showed extensive tubercle bacilli in the sections.[6,7,8,9] Usually, the blood alteration in tuberculous infection is mild and may consist of moderate anemia or leukopenia.[10,11] However, there are times when tuberculosis is accompanied by profound peripheral hematological changes that may mimic acute leukemia when it is not present.[12] The clinical differential diagnosis, whether the case may be only tuberculosis associated with monocytosis, as a leukemoid reaction or tuberculosis accompanied by acute monocytic leukemia, is important for treatment, especially since steroids are used for treatment of leukemia and are contraindicated in tuberculosis.[13]

A criterion of value in separating acute monocytic leukemia from tuberculosis is the platelet count since severe thrombocytopenia is much more likely to be associated with acute myelomonocytic leukemia than with tuberculosis. For that matter, the platelet count may be increased in tuberculosis.[9] A normal platelet count speaks against the diagnosis of acute leukemia. Bone marrow aspiration is definitely helpful as megakaryocytes are plentiful in tuberculosis and markedly diminished in acute leukemia. The total white blood cells in tuberculosis may range from 4,000 to 200,000/ul.[3] In acute leukemia, leukopenia is the rule.[14] The presence of Auer rods may be helpful in that their presence is considered by many to be diagnostic of acute myeloblastic or myelomonocytic leukemia.[15]

### Significance of Auer Rods

There are authors who differ in opinion regarding the significance of Auer rods.[16,17] Roth[18] and Feuchtinger[18] reported presence of Auer rods in two patients whom they considered to have "leukemoid reaction" due to tuberculosis. However, investigation during the past 69 years since Auer rods were first reported indicates the presence of Auer rods to be strong evidence of myeloblastic or myelomonocytic leukemia.[15] Reports nevertheless have appeared in the literature indicating the presence of Auer rods in patients who have tuberculosis who showed no hematologic or autopsy evidence of leukemia. These authors, however, contend that these leukemoid reactions associated with tuberculosis are "preleukemic" or "leukemic" and, this being the case, that there was not enough time for leukemic infiltration to take place in the visceral organs.[19]

In one study, leukemia was found in 12.8 per cent of the 86 patients who had tuberculosis.[20] On the contrary, there are reports which indicate that toxic effects of the tubercle bacilli modify the clinical course of acute leukemia.[21] For the most part, however, this has not been the case. Many cases reported in the literature indicate that treatment with antitubercular drugs generally improved the clinical picture, if only tuberculosis is present, which does not occur if tuberculosis is associated with acute monocytic or acute myelomonocytic leukemia. The only definite parameter to solidify the diagnosis of tuberculosis associated with acute leukemia is postmortem examination.

Despite not having the autopsy findings, we feel certain our case is one of acute myelomonocytic leukemia associated with tuberculosis in the lungs and urinary tract. The Auer rods seen in the blastic cells and his rapid downhill course despite anti-TB drugs justify this premise. The occurrence of monocytic or myelomonocytic proliferation in any case of tuberculosis should be carefully investigated because the treatment is an important facet to consider. As previously stated, steroids are included in most regimens of management of acute leukemia and should be used with extreme caution in cases of tuberculosis, or even not recommended.

### Acknowledgements

We wish to thank Nathaniel F. Rodman, M.D., Chairman, Department of Pathology, West Virginia University School of Medicine, for the electronmicrograph pictures, and Ms. Irene M. Muscatell for typing the manuscript.

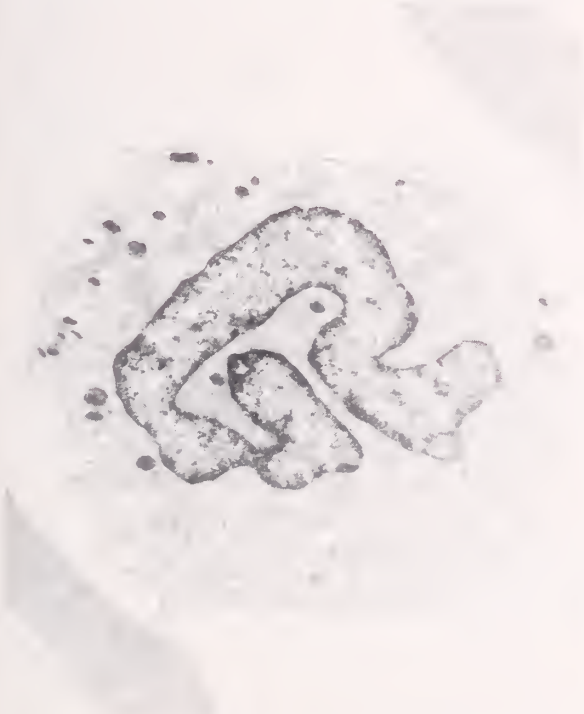

**Figure 3. Electronmicrograph—bone marrow of a leukemic myelomonocyte showing its infolded nucleus, vesiculated cytoplasm, well-developed Golgi system, and granules of heterogenous size, shape and density.**

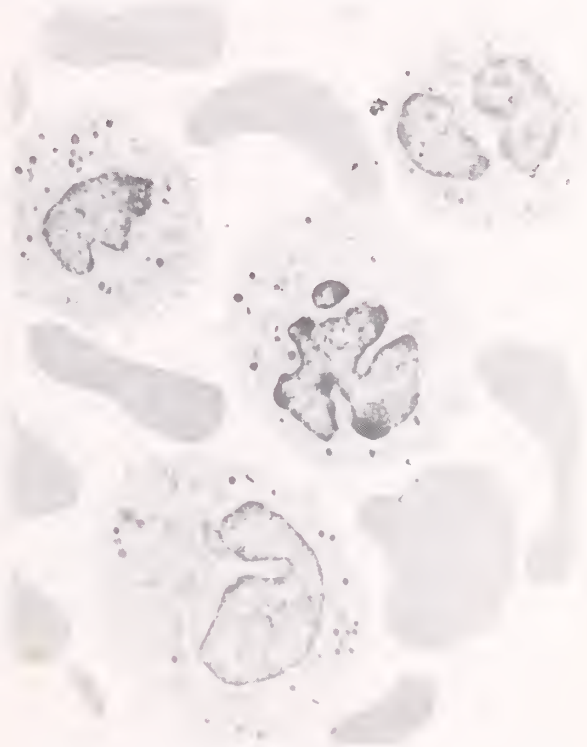

**Figure 4. Electronmicrograph — bone marrow showing myelomonoblasts with bizarre nuclei and prominent, enlarged nucleoli. Nuclei are infolded; note heterogenous granules in the cytoplasm.**

**Generic Drugs**

*Isoniazid:* Tablets, U.S.P., 100 mg and 300 mg tablets (Lilly)

*Rifampin:* Rifadin capsule, 300 mg (Dow)

*Ethambutal Hydrochloride:* Myambutal, 100 mg and 400 mg tablets (Lederle)

**References**


1. Hilts SV, Shaw CC: Leukemoid blood reactions. *New Engl J Med* 249:434-438, 1953.

2. Krumbhaar EB: Leukemoid blood picture in various clinical conditions. *Am J M ST* 172:519-533, 1926.

3. Mills ES, Townsend SR: Leukemoid blood picture in tuberculosis. *Can Med Assn J* 37:56-60, 1937.

4. Leibowitz S: Tuberculosis sepsis with myeloblastic blood picture. *Arch Path* 25:365-375, 1938.

5. Hill JM, Duncan CN: Leukemoid reactions. *Am J M SC* 201:847-857, 1941.

6. Roth C: Ueber einen be merkenswerteh Blutbefund bei einem, Fall von subakuter Miliartuberkulose. *Z Klin Med* 78:75, 1913.

7. Marshall M: A case of acute miliary tuberculosis. *Arch Intern Med* 16:1045, 1915.

8. Hayhoe FGJ: *Leukaemia: Research and Clinical Practice*, London, Churchill, pp 319-320, 1960.

9. Withers KL: Leukaemoid reactions in disseminated nonreactive tuberculosis: A review of the literature with report of a case. *Med J Austral* 142-144, 1964.

10. Muller GL: Clinical significance of the blood in tuberculosis. The Commonwealth Fund, New York, 1943.

11. Wintrobe MM. *Clinical Hematology*, Philadelphia, Lea and Febiger, p 264, 1961.

12. Hughes JR, Johnstone RM, Scott AC, Stewart PD: *J Clin Path* 12:307, 1959.

13. Skarberg KO, Lagerlof B, Reizenstein P: Leukaemia, lukameoid reaction and tuberculosis. *Acta Medica Scandinavia* Vol 182, fasc 4, 1967.

14. O'Brien JP: Non-reactive tuberculosis. *J Clin Path* 7:216, 1954.

15. Twomey JJ, Leavell BS: Leukemoid reactions to tuberculosis. *Arch Intern Med* 116:21-28, July 1965.

16. Auer J: Some hitherto undescribed structures in large lymphocytes in case of acute leukemia. *Am J Med Sci* 131:1002, 1906.

17. Whitby LEH, Britton CJC: *Disorders of Blood*, Philadelphia, Blakiston Co, p 529, 1939.

18. Feuchtinger O: Tuberkulose, akute leukamie and myeloische reaktion. *Klin Wschr* 22:669, 1943.

19. Milder E, *et al.*: Case of miliary tuberculosis simulating acute blastic leukemia. *JAMA* 177:106, 1961.

20. Muller GL: Clinical significance of blood in tuberculosis. London: The Commonwealth Fund, 1943.

21. Diamond LK, Luhby AL: Pattern of spontaneous remissions in leukemia of childhood. *Am J Med* 10: 238, 1951.


# Thalidomide Helpful In Skin Disease

THALIDOMIDE, the well-known drug that caused many cases of birth defects in European babies in the 1960s, is still being studied by researchers, and has been found useful in treating a particular skin infection, according to a report in a recent issue of Archives of Dermatology.

The drug has continued to be available under the trade name of Kevadon, for experimental purposes only. It is not licensed for other than research purposes.

Hans van den Broek, M. D., of the Hines (Illinois) Veterans Administration Hospital and the University of Illinois, Chicago, reported successful treatment of a case of prurigo nodularis, a skin ailment that causes rash and growths like boils.

Most therapies for prurigo nodularis have been unsuccessful, and some sufferers have been plagued with the disease for years. Doctor Broek read a report from Jerusalem of successful treatment with thalidomide in three cases, and decided to try it on his Illinois patient. Over a period of three months the lesions gradually flattened and the itchy rash disappeared.

# Medical Grand Rounds

**From the West Virginia University Medical Center**

Edited By
*Irma H. Ullrich, M. D.*
*Associate Professor of Medicine*

## Asbestos-Related Diseases Of The Lung

Discussant:
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*National Institute for Occupational Safety and Health; and WVU Section of Pulmonary Medicine*

*The relationship of asbestos exposure to mesothelioma, lung cancer and asbestosis has been clarified in the past two decades. It is now apparent that direct occupational exposure to asbestos is not necessary for disease. People indirectly exposed to asbestos in the construction industry, the shipyards or the asbestos workers' homes are considered to be at increased risk of developing asbestos-related disease. Of particular importance is the long latency period between exposure and clinically-detectable disease — usually more than 20 years.*

*Since asbestos exposure is often indirect and has occurred many years ago, a detailed occupational and family history is usually necessary to recognize the role of asbestos exposure in disease. This review is an attempt to summarize some of the relevant information associated with asbestos-related disease.*

Asbestos is a group of fibrous minerals with thousands of industrial uses. An association between environmental and occupational exposure to asbestos and the occurrence of asbestos-related disease is well established (Table 1). Asbestos-related disease diagnosed today is usually the result of exposure beginning many years earlier. Our challenge is not only to detect clinical illness early, but to educate potentially exposed workers and their families about the health risks of asbestos.

Prevention of these illnesses will be accomplished only by substituting safe materials and by limiting asbestos exposure in the workplace by appropriate engineering controls.

### Asbestos

Asbestos is divided into two classes, serpentine and amphibole, based on structural and chemical properties. Chrysotile is a serpentine asbestos and accounts for 95 per cent of world production. The fibers are long, silky, pliable and heat resistant, but poorly resistant to sea water and chemical digestion. Because of its flexibility, it is commonly woven into textiles. The larger deposits are in Russia's Ural Mountains and in Quebec, although some is found in Vermont.

Amphibole asbestos, in contrast to serpentine, is straight and rod-like and resistant to acids, heat and alkali. Crocidolite, amosite and anthophyllite are the common commercial varieties of amphiboles. Crocidolite and amosite are mined in South Africa, and anthophyllite is found in Finland. Among these three, anthophyllite is used least in commercial preparations due to the short and brittle nature of the fiber.[1]

Since the discovery of asbestos in 1870, world production has increased from 500 tons to

**TABLE 1**
**Asbestos-Related Pulmonary Effects**

1. Asbestosis (asbestos pneumoconiosis)
2. Pleural plaques
3. Pleural effusion (benign)
4. Pleural mesothelioma
5. Lung cancer

3,800,000 tons yearly in 1970.[2] Despite the growing recognition of asbestos-associated disease, world production increased 60 per cent in the 1960s.

Potential worker exposures occur during mining, milling, handling, manufacturing processes, and particularly, during the destruction of previously manufactured material. Once the fibers are incorporated into a manufactured item, there is little health risk unless the item is disrupted.

Asbestos is virtually indestructible and remains in the environment indefinitely.

In the United States, asbestos is used mainly in the manufacture of cement, paper, felt, floor tile and friction materials. Only two per cent of the world's production is used in marine insulation. Many manufactured products are composed of multiple fiber types.

### Parenchymal Penetration

Asbestos fibers which escape clearance by airway cilia penetrate into the lung parenchyma. Parenchymal penetration is inversely proportional to fiber diameter. Crocidolite, the thinnest, penetrates deepest; anthophyllite, the widest in diameter, penetrates least; amosite is intermediate in size and penetration. When the chrysotile fiber is long, despite the similarity in diameter to crocidolite, penetration is less than expected due to its serpentine shape.

Fibers may remain imbedded in the lung for years despite macrophage attempts to engulf and surround them.[3] With time, fibers coated with acid mucopolysaccharides form a matrix for iron deposition[4] (Figure 1). Sometimes referred to as "asbestos bodies," these coated fibers are more appropriately termed ferruginous bodies, as other inhaled fibers (e.g., talc, fibrous glass, cotton, and diatomaceous earth) are handled in like manner.

**Figure 1. Ferruginous bodies: Photomicrograph of lung parenchyma (magnified 1800x). "Beads" surrounding the asbestos fiber are a combination of iron and mucopolysaccharides. Uncoated asbestos fibers are seen in the lower portion of the photograph.**

Coating of fibers is thought to decrease fibrogenicity. Thus, coated fibers are not diagnostic of asbestos, although ferruginous bodies have most commonly been found to have an asbestos core.[5]

In the sputum of asbestos workers, the quantity of ferruginous bodies present has been correlated with duration of asbestos exposure.[6] Ninety-six per cent of urban dwellers over age 40 had ferruginous bodies present in their lungs. The number of ferruginous bodies was greater in the lungs of blue collar workers and, in particular, steel workers. This suggests that nearly all urban dwellers have some environmental asbestos exposure, and certain persons are subject to additional occupational exposure.[7]

### Asbestosis

The term "asbestosis" refers only to parenchymal fibrosis associated with asbestos exposure. The signs and symptoms are identical to other forms of diffuse interstitial fibrosis. The most important findings include a history of asbestos exposure, restricted lung volumes, and a chest x-ray compatible with asbestosis (Table 2).

The chest x-ray classically shows irregular basilar opacities which, in time, may progress to honeycombing (Figure 2). It commonly takes 15 years of exposure for these parenchymal changes to develop to an extent which is detectable on the chest roentgenogram. The radiographic specificity for asbestosis, which may be identical to other diffuse fibrotic processes, is enhanced when pleural thickening and, in particular, pleural calcification accompanies basal fibrosis.

Asbestosis is classically associated with restriction of lung volumes (functional vital

**TABLE 2**
**Asbestosis**

| | |
|---|---|
| 1. | Subjective dyspnea |
| 2. | Restrictive pulmonary function tests (FVC less than 80% predicted) |
| 3. | Finger clubbing |
| 4. | Basilar crepitations |
| 5. | Chest radiograph with increased basilar lung markings |
| 6. | Known asbestos exposure |

capacity <80 per cent predicted). Recent evidence suggests that small airway obstruction, due to peribronchial accumulation of asbestos dust, may also occur.[8] Serial follow-up of men with asbestosis showed that the decline in vital capacity was more than would be expected due to aging alone. A fall in diffusing capacity was the most sensitive measurement of a decrement in lung function, while one second forced expiratory volume ($FEV_1$), peak flow and $pO_2$ showed little change over time.[9]

Grossly, the extent of fibrosis present in the asbestotic lung varies from minimal amounts at the bases to a diffusely fibrotic, shrunken lung. Progressive massive fibrosis occurs rarely and, if present, suggests mixed dust exposure. Microscopically, early dust accumulation and fibrosis occur at the level of the respiratory bronchiole. The alveolar septae become thickened and infiltrated with mononuclear cells, neutrophils and macrophages. With further progression, diffuse alveolar wall thickening occurs with replacement of parenchyma by collagen[10] (Figure 3).

Important questions concern the development and progression of asbestosis. Which workers are predisposed to this disease? Is therapy effective? Does removing the worker with asbestosis from the work environment affect progression?

**Figure 2. Asbestosis: Increased irregular markings are present at the base and mid-lung zones. Blunting of both costophrenic angles is also present.**

Some investigators have found HLA-B27 more common in those with asbestosis compared to the general population.[11] Others, however, have failed to confirm this, and the presence of a genetic predisposition is uncertain.[12]

Radiographic signs of asbestosis can develop even after the worker has been removed from asbestos exposure.[13] In those with asbestosis, the number of workers with radiographic progression increased with the duration of follow-up.[14] Those with radiographic progression had a slightly greater frequency of positive antinuclear antibody and a higher titer compared to those whose disease did not progress. Also, those initially classified category 1/1 to 2/1 profusion (ILO U/C 1971 classification[15]) progressed minimally faster than those in other categories. It may be that the pathologic changes in the lung are more active at relatively early stages, and the antinuclear antibody level may be a marker for this increased cellular response.

The medical management of the patient with asbestosis is supportive. Steroids are not helpful. At present, "there is no real evidence to suggest that the only possible therapeutic intervention, namely, to remove the person from exposure, has any real influence on the outcome of the case."[2]

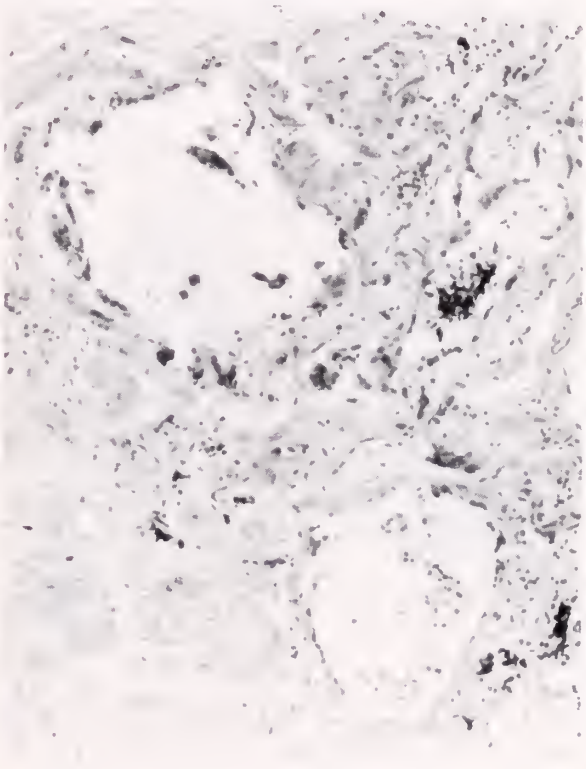

**Figure 3. Photomicrograph (magnified 80 x) of end-stage asbestotic lung. Note replacement of normal parenchyma with fibrosis.**

### Pleural Plaques (Fibrosis of the Parietal Pleura)

One of the radiographic hallmarks of asbestos exposure is pleural plaques. These are located on the parietal pleura, are not associated with pleural adhesions, and cause no pulmonary function impairment.

The pathogenesis of these plaques is unclear. Thomson[16] has suggested that inhaled fibers gradually penetrate toward the base and periphery of the lung in a migration propelled by the continual movement of the lung. He hypothesized that the common basal and posterior pleural plaques are a result of these areas being dependent when the subject is upright and during sleep. The tendinous part of the diaphragm, the ribs and the vertebral bodies block fiber penetration, and thus pleural plaques are typically located over these structures.

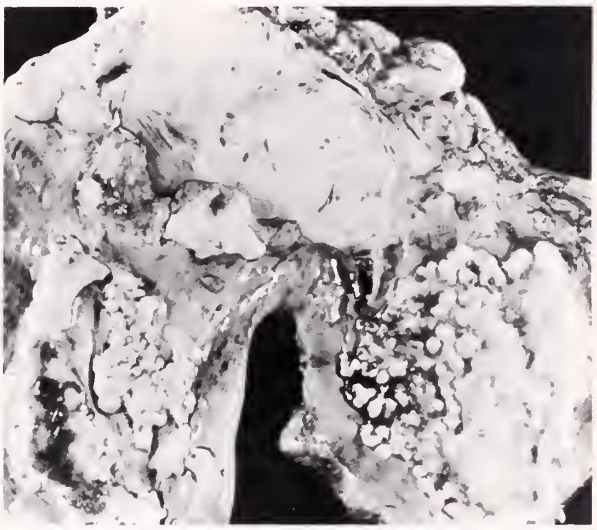

**Figure 4. Bilateral diaphragmatic plaques located on the central or tendinous part of the diaphragm. Despite their "soft" appearance on the chest radiograph, their consistency is similar to cartilage.**

**Figure 5. Bilateral pleural plaques. Note the plaque on the right is radiologically visible only along the lateral chest wall while the left plaque "wraps around" the lung.**

Grossly, the plaques are firm, raised areas with a nearly white, glistening surface[17] (Figure 4). Microscopically, the collagen fibers are oriented in a parallel fashion and are covered by a normal mesothelial lining which does not contribute to the development of the plaque. Therefore, the plaque is really extra-pleural. This, plus the slow, non-exudative growth of the plaque may explain the lack of adhesions. Pleural calcification occurs in areas of collagen degeneration and implies that the plaque has been present for 20 or more years.[18] Although they serve as markers of asbestos exposure, there is no evidence at present to suggest that pleural plaques are pre-malignant forms of mesothelioma.

The earliest finding on the chest radiograph of a pleural plaque is frequently a thin line of soft-tissue density at the lateral margin of the seventh or eighth rib.[18] This early change may be difficult to distinguish from normal "companion" shadows. The routine chest radiograph defines only eight to 15 per cent of all pleural plaques[19] (Figure 5). Oblique views may assist in their recognition.

### Malignant Mesothelioma

Mesotheliomas arise from the mesothelial cells of the pleura. Tumors may be solitary or diffuse. Solitary mesotheliomas are benign, well-circumscribed, variable in size and usually fibrous in histologic type, although epithelial elements may be present. They are unrelated to asbestos exposure and curable by surgical excision.

Diffuse mesothelioma has a gross appearance which is more diagnostic than its variable histologic appearance.[20] In its early stages, it appears as multiple gray or white nodules on either pleural surface. It spreads along the pleural surface, encasing the lung with a resulting loss of volume. Distant metastases beyond the regional lymph nodes are rare, unless advanced disease is present. The tumor has a predilection for growth along incision or biopsy sites. Microscopically, malignant mesothelioma may have one of three histologic patterns: epithelial, sarcomatous or mixed. Usually, one pattern predominates, but elements of the other two may be present.[21]

The relationship between mesothelioma and asbestos exposure was first well documented in 1960.[22] More recently, a study of 17,800 asbestos insulators uncovered 66 mesotheliomas.[23] Most occurred 30 or more years from onset of exposure. Mesothelioma is exceedingly rare in the non-asbestos exposed population, and the estimated mortality rate due to mesothelioma is one in 10,000 deaths per year in the general population.[24] Persons having household contacts with asbestos workers are also at increased risk for development of mesothelioma.[25]

### Symptoms

Symptoms develop insidiously and include progressive dyspnea, weight loss, and severe chest pain, which is often only partially relieved by analgesics. The presenting sign is usually a unilateral pleural effusion. As the disease progresses, affected supraclavicular nodes may become palpable and ribs may become tender as a result of local tumor invasion. Both superior and inferior vena caval obstruction can occur with resultant congestion, edema, and ascites. Digital clubbing may be present.

Malignant mesothelioma should be considered in the differential diagnosis of all cases of unexplained exudative pleural effusion, particularly if asbestos exposure is documented. Clinical clues suggesting mesothelioma include contralateral pleural plaques and pleural calcification. Commonly, mesothelioma is seen in the absence of basilar interstitial fibrosis, the classical finding of asbestosis.[26]

During thoracentesis, it may be difficult to enter the pleural space due to thickened pleura. The effusion is exudative, viscous and very cellular, with normal, malignant and inflammatory cells. Cytologic examination of the fluid is usually of limited diagnostic value because it is frequently difficult to differentiate benign from malignant mesothelial cells. Hyaluronic acid may be greatly elevated in effusions associated with malignant mesotheliomas.[27] Needle biopsy may aid in the diagnosis, but thoracotomy is often necessary to obtain adequate tissue for diagnosis. Because of rapid fluid accumulation, repeated thoracenteses may be necessary to palliate dyspnea.

The best approach to therapy includes a combination of surgery, radiotherapy and chemotherapy. Despite this, average survival time from onset of symptoms is only 12 to 15 months.[28]

### Lung Cancer

An association between asbestos exposure and bronchogenic cancer was first suggested in 1935, and, since that time many studies have documented this relationship.[29] The persistence of asbestos in the lung parenchyma may result in a life-long exposure to this carcinogen. Thus. despite removal of the worker from a contaminated environment, his lungs are continually exposed and the risk for cancer great. In one series, 60 per cent of English workers disabled due to asbestosis died of lung cancer.[30]

Seidman, *et al.* followed asbestos workers for 35 years from onset of work.[31] All workers, even those with less than one month work-related asbestos exposure, had an increased probability of developing lung cancer. This probability increased with duration of asbestos exposure. Older workers developed lung cancer after a much shorter latent period than workers exposed at a younger age. As well, those who worked longer in this environment developed lung cancer after a shorter latent period than those with less work exposure. Thus, the latency period from exposure to development of lung cancer depends not only on dosage but also on the age at which exposure occurs.

In another study of the same workers, the risk of lung cancer in cigarette smoking asbestos workers was compared to a group without asbestos exposure.[32] Asbestos workers who smoked one pack of cigarettes per day had an 87 fold increase in the risk of developing lung cancer compared to non-smoking, non-asbestos exposed controls. In non-smoking absestos workers, this risk was only five fold. These data suggest a synergistic effect of asbestos exposure and cigarette smoking in the causation of lung cancer.

### Acknowledgements

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### References

1. Constantinidis K: Asbestos exposure—its related disorders. *Br J Clin Pract* 31 (7/8):89, 1977.

2. Becklake MR: Asbestos-related disease of the lung and other organs: Their epidemiology and implication for clinical practice. *Am Rev Respir Dis* 114:187, 1976.

3. Brian JD, Valberg PA: Models of lung retention based on IRCP Task Group Report. *Arch Environ Health* 28:1, 1974.

4. Suzuki Y, Churg J: Formation of the asbestos body: A comparative study with three types of asbestos. *Environ Res* 3:107, 1970.

5. Churg A, Warnock ML, Green N: Analysis of the cores of ferruginous (asbestos) bodies from the general population. II. True asbestos bodies and pseudoasbestos bodies. *Lab Invest* 40:31, 1979.

6. Farley ML, Greenberg SD, Shuford EH Jr, *et al.*: Ferruginous bodies in sputa of former asbestos workers. *Acta Cytol* 21:693, 1977.

7. Churg A, Warnock ML: Correlation of quantitative asbestos body counts and occupation in urban patients. *Arch Pathol Lab Med* 101:629, 1977.

8. Rodriguez-Roisin R, Cochrane GM, Clark TJ: Asbestos exposure and small airway disease. *Scand J Resp Dis* 57(6):318, 1976.

9. Britton MG, Hughes DT, Wever AM: Serial pulmonary function test in patients with asbestosis. *Thorax* 32:45, 1977.

10. Hourihane DO'B, McCaughey WT: Pathological aspects of asbestos. *Postgrad Med J* 42:613, 1966.

11. Merchant JA, Klouda PT, Soutar CA, *et al.*: The HL-A system in asbestos workers. *Br Med J* 1:189, 1975.

12. Evans CC, Lewisohn HE, Evans JM: Frequency of HLA antigens in asbestos workers with and without fibrosis. *Br Med J* 1:603, 1977.

13. Becklake MR, Liddell FDK, Manfreda J *et al.*: Radiological changes after withdrawal from asbestos exposure. *Br J Ind Med* 36:23, 1979.

14. Gregor A, Parkes RW, duBois R, *et al.*: Radiographic progression of asbestosis: A preliminary report. *Ann NY Acad Sci* 330:147, 1979.

15. Jacobson G, Lainhart WS: ILO U/C 1971 International classification of radiographs of the pneumoconioses. *Med Radiogr Photogr* 48(3):65, 1972.

16. Thomson JG: The pathogenesis of pleural plaques, in *Pneumoconiosis, Proceedings of the International Conference*, Capetown, Oxford University Press, 1970.

17. Mattson SB, Rigqvist T: Pleural plaques and exposure to asbestos. *Scand J Respir Dis* Suppl No 75, 1970.

18. Fletcher DE, Edge JR: The early radiological changes in pulmonary and pleural asbestosis. *Radiol* 21: 355, 1970.

19. Hourihane DO'B, Lessof L, Richardson PC: Hyaline and calcified pleural plaques as an index of exposure to asbestos. A study of radiological and pathological features of 100 cases with a consideration of epidemiology. *Br Med J* 1:1069, 1966.

20. Saccone A, Coblenz A: Endothelioma of the pleura with a report of two cases. *Am J Clin Pathol* 13:186, 1943.

21. Churg J, Rosen SH, Moolten S: Histological characteristics of mesothelioma associated with asbestos. *Ann NY Acad Sci* 132:614, 1965.

22. Wagner JC, Sleggs CA, Marchand P: Diffuse pleura mesthelioma and asbestos exposure in the North Western Cape province. *Br J Ind Med* 17:260, 1960.

23. Selikoff IJ, Hammond EC: Asbestos-associated disease in United States shipyards. *CA* 28(2):87, 1978.

24. Selikoff IJ, Churg J, Hammond EC: Relation between exposure to asbestos and mesothelioma. *N Engl J Med* 272:560, 1965.

25. Anderson HA, Lilis R, Daum SM, *et al.*: Asbestosis among household contacts of asbestos factory workers. *Ann NY Acad Sci* 330:387, 1979.

26. Legha SS, Muggia FM: Pleural mesothelioma: Clinical features and therapeutic implications. *Ann Int Med* 87:613, 1977.

27. Rasmussen KN, Farber V: Hyaluronic acid in 247 pleural fluids. *Scand J Respir Dis* 48:366, 1967.

28. Legha SS, Muggia FM: Therapeutic approaches in malignant mesothelioma. *Cancer Treat Rev* 4:13, 1977.

29. Lynch KM, Smith WA: Pulmonary asbestosis III: Carcinoma of lung in asbestos-silicosis. *Am J Cancer* 24:56, 1935.

30. Wagner JC: Asbestos carcinogenesis. *Br J Cancer* 32:258, 1975.

31. Seidman H, Selikoff IJ, Hammond EC: Short-term asbestos work exposure and long-term observation. *Ann NY Acad Sci* 330:61, 1979.

32. Hammond EC, Selikoff IJ, Seidman H: Asbestos exposure, cigarette smoking and death rates. *Ann NY Acad Sci* 330:473, 1979.

113th ANNUAL MEETING

of the

# *West Virginia State Medical Association*

*The Greenbrier*

AUGUST 20-23, 1980

# PLAN NOW TO ATTEND

*A message from . . .*

*The President*

## THE FUTURE

ASIDE from Medicine, there is no other group or profession other than, perhaps, the clergy which looks so consistently to the future for its rewards and satisfaction.

We endure eight to 12 more years of education while high school classmates become employed, marry, have children, build houses and places in the community. We teach and sometimes scold good living habits, preach safety, prescribe diets and rehabilitate all to assure a better future.

We learn quite literally to put off the immediate gratification of our impulses in order to assure a greater return in the future. Above all, we plan in order that we might make the future to some extent predictable and thus avoid the host of tragic surprises life holds in store for the unwary.

Organizations, too, must plan and, to whatever extent possible, arrange the future. Your Association has been looking to the future. One of the most rewarding meetings I have attended in some time was the recent meeting of the State Association Long Range Planning Committee.

Under the chairmanship of Dr. Richard E. Flood of Weirton, exciting yet pragmatic ideas were presented, refined and recommended to Council. With an initial acknowledgment that no beneficent aims can be achieved without a strong organization, the Committee focused its attention on strengthening the Association by encouraging increased participation by the members in its activities.

A complete report of the Committee's proceedings will be published.

It is almost fashionable these days to speak with dark foreboding on almost any serious subject—energy, ecology, the economy, international affairs—and Medicine has certainly been included in this list. I am more optimistic than most on all matters listed but, without reservation, I am very optimistic about the future of Medicine.

I do not suggest that Medicine will not change. To expect that Medicine might remain static would be to view matters from the depths of pessimism, and would ignore the dynamic and even startling changes which have occurred throughout the history of Medicine and, in particular, during the past 50 years.

Let us hope the opportunity for change will not pass us by, and let us also hope that we will remain vigilant enough to shape, modify and channel change to the satisfaction of the medical community and to the ultimate best good of our patients. I am satisfied that your Association will be prepared to seize opportunities presented by events of the future.

Stephen D. Ward, M.D.

STEPHEN D. WARD, M. D., *President*

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

It is never our editorial intention to make like a broken record. But it is time, once more, to make this earnest recommendation to physicians:

Somehow, doctors must find time amid their busy and demanding schedules to pay increasing amounts of attention to health planning activities in West Virginia. Nothing can be more threatening to accessibility and quality of health and medical care than misdirection in this maze of activity.

**A NEW CHANCE FOR MISCHIEF**

The latest "jewel" on the horizon is something called "appropriateness review." It is about to be launched as a joint effort by the West Virginia State Health Planning and Development Agency (SHPDA) and the West Virginia Health Systems Agency, Inc. (HSA).

The two agencies say the process "is designed not only to satisfy all the mandated state and federal legalities, but hopefully, to allow the citizens of West Virginia an opportunity to participate in the design and implementation of such a review program."

Simply stated, the new and highly cumbersome effort will review specific institutional health services and home health services to determine if they meet the needs of the population of the state "in accordance with established criteria."

The services subject to review cover about everything within the range of medical care provided on an inpatient basis—obstetrics; neonatal care; pediatrics; acute psychiatric services; special care such as pulmonary, cardiovascular and a host of others; surgery; specialized coronary care; radiation therapy; computed tomography; emergency medical care; end-stage renal disease, and long-term institutional care.

The current schedule calls for completion of a review of each of these services on a statewide basis by June 30, 1983 — and a written finding as to the appropriateness of each such service. The finding is to be transmitted to all health care providers — and the public will be advised of such finding through newspaper publication.

It is understood that this initial statewide review of the institutional and home health services will be followed, in a subsequent cycle, by a review of such services on an individual institution basis, again with public notification of findings.

It is immediately apparent that the potential impact of appropriateness review is awesome. It literally will embrace every procedure and phase of care provided by physicians in a hospital or home health care setting.

The most critical feautre of the process, it appears, will surface in the very beginning, in the selection of criteria to be used to measure service appropriateness. Again, it's understood that task forces of physicians and other providers in each of the areas of service will be utilized to help develop fair, professional and logical standards of measurement. In this activity the expertise and understanding of physicians are essential.

Criteria are to embrace such things as accessibility, quality and cost of care; coordination among various kinds of services within the health care system, and consistency with the State Health Plan. The criteria, along with other components of the process, will be subject to public review and comment.

There are to be no sanctions applied to any institution when there are findings of inappropriateness of service — but this "concession" really means nothing. If an improperly-fashioned, non-professional and just plain wrong finding should be made, and is published in a newspaper, who needs sanctions?

Where all of this appropriateness review process will lead is uncertain, at best. It's significant, we feel, that some of the health planning professionals are uncomfortable, privately, with

federally-mandated review schedules and some other features.

In the final analysis, however, it's another element of the highly complex, bureaucratic and expensive health planning program that now is upon us. Physicians and others who have the real knowledge about how to provide quality of care must, in some manner, stay in the thick of things for the welfare of their patients.

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In perhaps its most intensive legislative effort ever, the West Virginia State Medical Association engineered this year an unprecedented and complete rewrite of the State's Medical Practice Act. Now there's some thinking afoot that might seriously undermine much of the progress made.

**ANOTHER LAYER OF BUREAUCRACY**

The new licensing law is not perfect. Some technical refinements almost certainly will have to be made in future legislative sessions. But the new West Virginia Board of Medicine should have a chance to begin implementation of the statute, with its greatly tightened machinery for disciplinary and other action, without interference.

Getting some attention in the Legislature's between-sessions Joint Committee on Government Operations, however, is a draft of a bill that simply could mean trouble. It would set up a new, umbrella-type Board of Professional and Occupational Regulation that would have a super-power position over existing licensing and regulatory agencies.

Modeled in significant degree after a recent Virginia enactment which has received decidedly mixed reviews, the bill would seek to consolidate in the super agency various administrative functions of existing boards while purportedly leaving individual board responsibilities largely undisturbed. At a quick glance, there might appear to be some logic in this thinking — but we think that view collapses quickly with a little additional inspection.

First, we question the need for, or desirability of, another layer of bureaucratic regulation. There's the strongest kind of argument for less, not more, government. In addition, there's been a provision in West Virginia law since 1977 for an executive secretary to coordinate fiscal and other activities of health profession licensing boards — a provision that's never been implemented because of some practical problems that remain unsolved. Maybe some new efforts should be made to get this language operable, rather than get involved with new legislation.

Several other provisions of the draft before the legislative committee at this writing also have given rise for concern. There are, for example, no qualifications whatsoever set out for the nine persons who would be appointed by the governor to the new superboard. There thus is no provision for representation on the board of existing licensing and regulatory agencies as a means of providing some linkage with ongoing activity.

An expressed objective of providing citizen access to regulatory boards likewise won't hold water, because other 1977 legislation mandates lay members on licensing boards. Still other provisions in the bill would create a double layer of enforcement of licensing and related regulations. And the idea of making uniform procedures, forms, fees, rules and regulations supposedly common to some 25 or 30 existing boards probably is unrealistic because there isn't all that much which is common.

We also find unrealistic and impossible a provision that an inspection shall be made at least once each two years as to the practice of "each practitioner certified or licensed" by each regulatory board in the State. This inspection would be to "ensure that each practitioner is conducting his practice in a competent manner and within the lawful rules and regulations promulgated by each board . . ."

And what about power to be given the executive secretary of the superboard to "maintain all records for each (existing) board?" What happens to confidentiality of Board of Medicine records, and medical confidentiality in general, which the new Medical Practice Act goes to such lengths to protect in the interest of due process and other respects?

In short, we don't like what we see in the professional licensing bill. Our position certainly will be one of strong opposition.

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National Health Insurance sparks remain aglow. The U.S. Senate Finance Committee, under the whiphand of Chairman Russell Long, Louisiana Democrat, has scheduled six days of meetings on the issue this summer.

**SPARKS AGLOW**

The bill before the Committee has been cut back to make it easier to win approval. The catastrophic provision was changed to a voluntary plan with tax incentives to encourage businesses to buy such coverage for their workers

Probably nothing will happen this year. But when Senator Long runs the show and wants a bill, it's never wise to write off the legislation involved.

*(Editor's Note: The following article appeared in a recent issue of a publication for medical and dental staff officers at the Ohio Valley Medical Center, Inc., in Wheeling. It was written by Harry S. Weeks, Jr., M.D., a Past President of the West Virginia State Medical Association; and current President of both the West Virginia Medical Institute, Inc., and the American Association of Professional Standards Review Organizations. It offers, in the opinion of The Journal's Editors, a concise and highly understandable picture of the origin and development of the Professional Standards Review Organization (PSRO) Program.)*

## PSRO—PAST AND FUTURE

Late in February, I had breakfast in Salt Lake City with former U.S. Sen. Wallace Bennett, the person responsible for the PSRO program. As one might imagine, the table talk turned to the inception and future of the PSRO program in this country.

According to Senator Bennett, the Senate Finance Committee in 1970 was concerned with fraud and abuse in the Medicare and Medicaid programs, and out of this concern grew the PSRO program. Senator Bennett, assigned the task of developing legislation, was faced with two problems — how to prevent direct surveillance of medical records of federal pay patients by federal agencies; and how to achieve a balance between the federal government and the medical profession in guaranteeing that the medical services rendered were of an acceptable quality.

The final result, passed in 1972, was Public Law 92-603, which allowed for the establishment of groups of physicians into Professional Standards Review Organizations. Essentially, they were charged with quality assurance activities in reviewing patients' records treated in acute care hospitals, long-term care facilities and ambulatory settings.

The PSRO program has never been fully funded and hence has not been involved in the full range of activities legislated. Certain possible activities, such as in-office review, would be too costly to merit serious consideration. The emphasis to date has been in reviewing acute care hospitalizations for medical necessity and appropriateness of care based on locally developed or accepted norms and criteria.

Given the circumstances of the physicians, who neither wanted further federal instrusion into their lives or their patients' nor were anxious to accept responsibilities of a considerable magnitude, and DHEW, a federal department not known for a pro-physician stance, it is remarkable, to some, that the program has matured to its present state. To those physicians working within the program, the driving force is to keep physicians involved in making decisions on the quality of medical care and to prevent further federal intrusion by assuming a concrete role of responsibility.

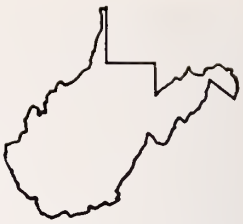
That the program has been controversial is also understandable. A profession, not used to working with the federal government, and a highly organized federal bureaucracy, not used to assuming a role of cooperation with physicians, makes for a rocky road. At present, given our economic and political circumstances, the emphasis is on cost containment. There is little emphasis on quality by those responsible for answering to Congress and the public.

The program is working well and it is cost effective. In West Virginia last year, between 4 and 10 million dollars were saved. Such calculations are subject to considerable interpretation, but this was done on a budget of just over one million dollars, which included hospital reimbursement. DHEW and The White House have recognized PSRO effectiveness by asking for a 30-per cent increase in its budget for fiscal year 1981. Congress may decide differently, but it appears at present that the future of the PSRO program still rests with physicians.

At present, individual PSROs are looking into the quality aspects of medical care by focusing in on potential problem areas — be they hospitals, diagnoses, physicians or patients. They are increasing their educational efforts and, where those mechanisms fail, resorting to removal of waiver, de-delegation, sanctions and other disagreeable but necessary activities.

DHEW's present flirtation with establishing national goals for local PSROs is also causing additional stress. That there are problems is becoming a matter of record. That the quality of medical care is amazingly high and uniform must also be made a matter of record. How the medical profession deals with the problems it sees, and maintains or improves upon the quality of medical care, will determine the future of this program and the medical profession in this country.

# GENERAL NEWS



## AMA Speakers Scheduled For Annual Meeting

Speakers on the services and activities of the American Medical Association are included on the program for the 113th Annual Meeting of the State Medical Association August 20-23 at the Greenbrier in White Sulphur Springs.

Clinton S. McGill, M.D.

James E. Drake

Clinton S. McGill, M.D., of Portland, Oregon, and James E. Drake of Washington, D. C., will speak during the third general session on Saturday morning, August 23, it was announced by the Program Committee.

Doctor McGill, a member of the AMA's Speakers' Bureau, will talk on "AMA Membership and Other Services," while Drake's topic will be "The AMA in Washington." Drake is Director, Department of Congressional Relations, AMA Washington Office.

Announcement of the two speakers completes the program for the 1980 convention.

Activities will get under way with a 2 P.M. meeting of the Association's Executive Committee on Tuesday, August 19; the usual pre-convention meeting of the Council at 9:30 A.M. on Wednesday, and the first session of the House of Delegates at 3 o'clock that afternoon.

Dr. Robert B. Hunter of Sedro Woolley, Washington, as announced previously, will address the opening House session Wednesday. He will be installed as AMA President this month.

Delivering the keynote Thomas L. Harris Address during 9 A.M. opening exercises on Thursday, also as announced previously, will be Dr. William R. Barclay, Editor of The Journal of the American Medical Association (JAMA). The first general session will be held immediately following the opening exercises. Doctor Barclay will speak on "Scientific Journalism: The Backbone of Professionalism."

Doctor McGill was a member of the Board of Trustees (two years) of the American Society of Internal Medicine, and was a charter member of the Oregon Chapter, ASIM.

He was a member of the AMA House of Delegates for four years, and currently is the AMA Representative on the Joint Mediation Team for Hospital Administration-Staff Disputes.

Doctor McGill has served the Oregon Medical Association in a number of posts, including those as Speaker of the House of Delegates and as a member of the Association's Board of Trustees and Executive Committee.

He received his M.D. degree from the University of Oregon Medical School, and completed his internship and residency at Henry Ford Hospital in Detroit.

While serving as Medical Director of the Oregon Public Welfare Commission (part-time) in the 1950s, he co-authored the nation's first Permanent and Total Disability Program.

He also has held a number of leadership positions with the Oregon Medical Political Action Committee (OMPAC).

### Joins AMA Staff in 1975

Drake joined the AMA's Washington Office as Assistant Director, Department of Congressional Relations, in 1975, being named Director in January of this year.

In his early career, he was News Director for WSM-Television in Nashville, Tennessee, and later was Administrative Assistant to Congressman Richard Fulton from Tennessee.

He completed his undergraduate work at the University of Tennessee in Knoxville, and received B. S. and M. S. degrees in journalism from Northwestern University, Evanston, Illinois.

The speakers and topics for the first general session on Thursday morning, as announced

previously, will be "Advances in Photochemotherapy" — Harry M. Robinson, Jr., M.D., Professor Emeritus, Division of Dermatology, University of Maryland School of Medicine; "Diagnostic Dermatologic Methods" — Joseph W. Burnett, M. D., Professor and Chairman, Division of Dermatology, University of Maryland School of Medicine; and "Food- and Drug-Induced Diseases"—Donald S. Robinson, M. D., Chairman, Department of Pharmacology, Marshall University School of Medicine.

#### Chronic Mental Illness

Rogers J. Smith, M. D., of Portland, Oregon, Chairman of the AMA Council on Scientific Affairs, will be the first speaker for the second general session on Friday morning. His topic will be "The Primary Physician's Role in Care of the Chronically Mentally Ill."

Also speaking during the second general session will be Patrick R. Staunton, M. D., Chairman, Division of Psychiatry, Lutheran General Hospital, Park Ridge, Illinois, "The Chronic Mental Patient — Resources Necessary for Optimal Care," and William B. Svoboda, M. D., Associate Professor, Pediatrics and Neurology, West Virginia University School of Medicine, "Learning Disabilities Associated with Medical Problems."

The general convention format once again will provide opportunities for breakfast, luncheon and other meetings, of a scientific and/or business nature, of the various sections and specialty organizations affiliated with the Medical Association. It is anticipated that the bulk of these again will be scheduled on Friday (August 22).

Plans also call for the usual President's Reception on Wednesday evening, August 20, and the Saturday evening reception for new officers. The latter will follow the second and final House of Delegates session at 2:30 P. M. on Saturday. At that House session, Dr. L. Walter Fix of Martinsburg will be inaugurated as President to succeed Dr. Stephen D. Ward of Wheeling.

#### Program Committee

Members of the Program Committee are Dr. M. D. Reiter, Wheeling, Chairman; Doctor Fix, and Drs. David K. Heydinger, MU School of Medicine, Huntington; Joseph B. Reed, Buckhannon; Stanley Roy Shane, WVU School of Medicine, Morgantown, and John F. I. Zeedick, South Charleston.

The Annual Meeting of the Auxiliary to the State Medical Association, with Mrs. D. Sheffer Clark of Huntington in charge as the Auxiliary's President, again will run concurrently with the Association's convention.

The complete convention program, including the schedule and speakers for related meetings, physicians who will serve as moderators, and other details, will appear in the August issue of *The Journal.*

## 65 Of WVU Medical School Faculty Promoted

Of the 188 West Virginia University faculty members promoted or granted tenure, effective July 1, 65 are affiliated with the School of Medicine.

The promotions, based upon performances in teaching, research or public service, were approved by the West Virginia Board of Regents and announced by B. A. Nugent, Vice-President for Academic Affairs, and Charles E. Andrews, M. D., Vice-President for Health Sciences, who conducted detailed reviews before making recommendations to the Board.

Advanced to the following ranks are:

R. Stephen Amato, Associate Professor, Peditrics, granted tenure; James G. Arbogast, Assistant Professor, Family Practice; John U. Bell, Associate Professor, Pharmacology and Toxicology; Carole B. Boyd, Associate Professor, Pathology, granted tenure; Nyles Charon, Assistant Professor, Microbiology, granted tenure; Eugene V. Cilento, Research Assistant Professor, Anatomy; John P. Claude, Assistant Professor, Behavioral Medicine and Psychiatry, granted tenure; David A. Clayman, Associate Professor, Behavioral Medicine and Psychiatry, granted tenure; Brenda K. Colasanti, Professor, Ophthalmology, Pharmacology and Toxicology; Thomas W. Crosby, Associate Professor, Pathology and Neurology, granted tenure; Michael Crouch, Associate Professor, Medicine; Stuart Deglin, Associate Professor, Medicine; Amy Dorn, Assistant Professor, Medicine; Ralph O. Dunker, Associate Professor, Neurosurgery.

Rama Ganguly, Associate Professor, Medicine; Maria Georgiev, Associate Professor, Medicine; Robert W. Graves, Professor, Pharmacology and Toxicology; David E. Hinton, Associate Professor, Anatomy, granted tenure; G. Paul Hlusko, Associate Professor, Behavioral Medicine and Psychiatry, granted tenure; Jean D. Holter, Assistant Professor, Pathology, granted tenure; David Hoover, Assistant Professor, Medicine; Ellen Hrabovsky, Associate Professor, Pediatrics, granted tenure; Robert Hutton, Assistant Professor, Surgery; S. N. Jagannathan,

Associate Professor, Pathology, granted tenure; Jesse J. Jenkins, Associate Professor, Pathology, granted tenure; Rashida Khakoo, Associate Professor, Medicine; Ronica Kluge, Professor, Medicine; Martin J. Kommor, Associate Professor, Behavioral Medicine and Psychiatry; R. Bruce Martin, Associate Professor, Orthopedic Surgery, granted tenure; Roxann Powers, Assistant Professor, Medicine; Mark J. Reasor, Associate Professor, Pharmacology and Toxicology; John Rogers, Associate Professor, Medicine.

Jean Ross, Associate Professor, Pediatrics, granted tenure; James Savory, Assistant Professor, Medicine; Richard J. Seime, Associate Professor, Behavioral Medicine and Psychiatry, granted tenure; Narinder N. Sehgal, Associate Professor, Obstetrics and Gynecology, granted tenure; Sheila Shah, Associate Professor, Pathology, granted tenure; Stephen T. Slack, Associate Professor, Radiology; James Stevenson, Professor, Behavioral Medicine and Psychiatry; Irma Ullrich, Associate Professor, Medicine, granted tenure.

The 25 *clinical* faculty promotions include:

Ali AbuRahma, Assistant Professor, Surgery; Carl C. Barger, Associate Professor, Radiology; Bruce L. Berry, Assistant Professor, Obstetrics and Gynecology; Brian Boehlecke, Adjunct Associate Professor, Medicine; Bobby L. Caldwell, Professor, Pathology; William H. Carter, Professor, Medicine; Barry L. Edelstein, Associate Professor, Behavioral Medicine and Psychiatry, granted tenure; Dominic J. Gaziano, Professor, Medicine; Robert L. Ghiz, Associate Professor, Orthopedic Surgery; David B. Gray, Professor, Surgery.

Vera L. Hoylman-Ayoubi, Associate Professor, Pediatrics; Chungwhan W. Kim, Assistant Professor, Surgery; Derrick L. Latos, Associate Professor, Medicine; Luis A. Loimil, Assistant Professor, Orthopedic Surgery; Samuel P. McNeill, Assistant Professor, Family Practice; Eric P. Mantz, Assistant Professor, Surgery; Lee H. Pratt, Associate Professor, Neurology; Samuel K. Roberts, Assistant Professor, Family Practice; Ralph S. Smith, Jr., Associate Professor, Behavioral Medicine and Psychiatry; Jackie Lee Summers, Associate Professor, Urology; Shirley W. Trammel, Assistant Professor, Surgery; Purushottam Verma, Assistant Professor, Pediatrics; David J. Withersty, Professor, Behavioral Medicine and Psychiatry; John Joseph Zarski, Associate Professor, Behavioral Medicine and Psychiatry; John F. I. Zeedick, Professor, Anesthesiology.

## Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb. Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal).

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

| | | |
|---|---|---|
| July 12 | Charleston | CAMC Oncology Symposium: Update on the Management of Melanoma |
| Sept. 5-6 | Morgantown | Urology Reunion Days |
| Sept. 25-26 | Morgantown | 6th Annual Hal Wanger Family Practice Conference |

### Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

*Cabin Creek* (2nd Wed., 8-10 A. M.)

July 9

| | |
|---|---|
| Common Gynecological Disorders | Narinder N. Sehgal, M. D. |

*Welch, Stevens Clinic Hospital* (3rd Wed., 11 A. M.-1 P. M.)

August 20

| | |
|---|---|
| Office Dermatology | Robert B. Point, M. D. |

*Buckhannon, St. Joseph's Hospital*
(4:30-6 P. M.)

September 18

| | |
|---|---|
| Infectious Diseases | Patrick Robinson, M. D. |

## AMA House Of Delegates Meets July 20-24

The 129th annual meeting of the American Medical Association will be held July 20-24 in Chicago.

The official call for the meeting was published in the May 23/30 Journal of the American Medical Association.

**Richard E. Flood, M. D.**

**Frank J. Holroyd, M. D.**

The 280 members of the AMA House of Delegates will meet in the Chicago Marriott Hotel for deliberations that will set policy. Socio-economic subjects such as cost of health care and health care delivery will be on the agenda, as well as consideration of medical-scientific issues.

The House of Delegates is composed of representatives from state medical associations, national medical specialty societies, resident physicians, medical students, medical schools, medical corps of the Army, Navy and Air Force, U.S. Public Health Service and Veterans Administration.

Presiding will be William Y. Rial, M.D., of Swarthmore, Pennsylvania, Speaker of the House, with Harrison L. Rogers, Jr., M.D., of Atlanta, as Vice Speaker.

Hoyt D. Gardner, M.D., of Louisville, is President of the AMA. President-elect is Robert B. Hunter, M.D., of Sedro Woolley, Washington. Chairman of the Board of Trustees is Lowell H. Steen, M.D., of Hammond, Indiana.

The West Virginia State Medical Association's two Delegates to the AMA House of Delegates are Drs. Richard E. Flood of Weirton and Frank J. Holroyd of Princeton, with Drs. Jack Leckie of Huntington and Harry S. Weeks, Jr., of Wheeling as Alternate Delegates.

Doctor Weeks has been nominated by the AMA Board of Trustees for the AMA's Council on Medical Services. Doctor Weeks' nomination and five other nominations for two positions on the Council will be submitted to the House of Delegates.

Doctor Flood will be a member of Reference Committee H, which will consider, and report back to the House on, resolutions in a number of topic areas.

## Doctors Ketchum and Wiles Nominated For House

Dr. Dorsey Ketchum, Huntington Democrat, won renomination for the West Virginia House of Delegates from the 11th Delegate District in the state's June 3 primary election. The District has six House seats.

In the 27th District, Dr. Isaiah A. Wiles of Morgantown, a former Monongalia County Health Director, was among four Republican nominees for the House.

**Some of the nation's outstanding cataract and intraocular lens surgeons gathered at The Blaydes Foundation in Bluefield for an intensive, two-day meeting this spring. Shown above implanting intraocular lenses in model eyes are, from left, Drs. Robert Peiffer of the University of North Carolina, Dr. Wallace Strow, Springfield, Illinois; Dr. William Simcoe, Tulsa, Oklahoma, and Dr. Conrad Henry, Norfolk, Virginia.**

## Symposium To Honor Late Huntington Surgeon

Five physicians from the Mayo Clinic will participate in a symposium honoring the late William E. Irons, M. D., of Huntington on Monday, September 8.

"The William E. Irons, M. D., Surgical Symposium," beginning at 8:45 A. M. and adjourning at 4:15 P. M., will be held at the Marshall University Memorial Student Center.

Sponsors are Marshall University School of Medicine and St. Mary's Hospital in Huntington.

Doctor Irons, who died in 1979, completed his surgical residency at the Mayo Clinic, and was a former Chief of Surgery at St. Mary's. He held an undergraduate degree from MU.

Three of the Mayo Clinic physicians will speak during the morning panel session on biliary tract disease. They are Drs. John Thistle, Division of Gastroenterology; Robert MacCarty, Department of Radiology, and Oliver Beahrs, Department of Surgery.

The Mayo Clinic speakers for the afternoon session on breast cancer will be Doctor Beahrs and Drs. Richard G. Hahn, Department of Oncology, and George B. Irons, Section of Plastic Surgery. Doctor Irons is a nephew of the late Doctor Irons.

A reception for alumni of the Mayo Clinic will be held during the symposium.

The fee for physicians will be $30; residents, $10 (with letter from chief of staff); and nurses, $10. There will be a luncheon fee of $5 for medical students (with letter from the dean's office).

Registration and other information may be obtained from Charles W. Jones, Ph. D., Coordinator of Continuing Medical Education, Marshall University School of Medicine, Huntington 25701. Telephone (304) 696-6755.

Additional symposium details, including titles of addresses, will appear in the August issue of *The Journal.*

## AMA Names Doctor Ward To Dental Council

Dr. Stephen D. Ward of Wheeling, President of the State Medical Association, has been named to represent the American Medical Association on the Legislative Council of the American Dental Association.

Doctor Ward, who is Editor of *The West Virginia Medical Journal*, also is a member of the AMA Council on Legislation.

**New officers and council members recently were elected by the West Virginia Chapter of the American College of Surgeons during its spring meeting at White Sulphur Springs. They are, from left, front row, Drs. William E. Gilmore of Parkersburg, First Vice President; Walter E. Klingensmith, Beckley, Past President; Robert L. Bradley, Huntington, President, and Herbert G. Dickie, Wheeling, Governor; second row, Drs. Roger E. King, Morgantown, and Catalino B. Mendoza Jr., Clarksburg, Councillors; Alvin L. Watne, Morgantown, Secretary-Treasurer; George J. Hill II, Huntington, and James P. Thomas, Bluefield, Councillors. Also elected to office was Dr. Stanley J. Kandzari, Morgantown, who was named Second Vice President.**

## Residents Receive Prizes At Surgeons' Meeting

Three residents at the West Virginia University Medical Center received prizes for their presentations at the spring meeting of the West Virginia Chapter of the American College of Surgeons held recently at the Greenbrier.

First prize was awarded to Dr. William Tarry of the Department of Urology for his paper on "Radio Immunoassay of Endogenous Steroids in Adenocarcinoma of the Prostate."

Dr. Robert A. Gustafson of the Department of Surgery received second prize for his paper on "Changing Concepts in Splenic Trauma," and third prize went to Dr. Samuel R. Whitaker of the Department of Otolaryngology for his presentation on "Juvenile Nasopharyngeal Angiofibroma."

During the meeting, Dr. Alvin L. Watne, WVU Professor and Chairman of Surgery, gave a brief history of the West Virginia Chapter and made a presentation of an honorary gavel to Dr. John O. Rankin of Wheeling, a founding member.

**Donald C. Carter, M. D., left, Professor of Behavioral Medicine and Psychiatry, and Michael E. Crouch, M. D., Assistant Professor of Medicine, were honored by students in the West Virginia University School of Medicine at the annual awards convocation this spring. Doctor Carter received the MacLachlan Award, given to an outstanding teacher chosen by the sophomore class. Doctor Crouch was named Clinician of the Year by the seniors. (See article on other award recipients on Page xii.)**

# *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*General Ophthalmology*, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 410 pages. Price $15. Lange Medical Publications, Los Altos, California 94022. 1980.

*Current Pediatric Diagnosis and Treatment, 6th Edition*, by C. Henry Kempe, M. D.; Henry K. Silver, M. D.; and Donough O'Brien, M. D. 1122 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1980.

*Review of Medical Microbiology, 14 Edition*, by Ernest Jawetz, Ph.D., M. D.; Joseph L. Melnick, Ph.D.; and Edward A. Adelberg, Ph.D. 592 pages. Price $14. Lange Medical Publications, Los Altos, California 94022. 1980.

*Handbook of Obstetrics & Gynecology, 7th Edition*, by Ralph C. Benson, M. D. 807 pages. Price $10. Lange Medical Publications, Los Altos, California 94022. 1980.

## 88 Members In New WVU Class Announced

Women will make up more than one-fourth of the new class of 88 students who will enter the West Virginia University School of Medicine in late August.

The 23 women, two more than the record number admitted in 1978, are residents of West Virginia as are 61 of their male classmates.

The cumulative grade point average for the accepted applicants was up from last year's 3.52 to 3.58. This year's science average of 3.50 was the same as that of the 1979 entering class. (4.0 is perfect—all A's.)

Six members of the new class have degrees past the bachelor's level.

Those admitted completed their undergraduate education at 33 different institutions — 39 were students at WVU, 22 attended Marshall University or West Virginia colleges, and 27 at-

(Continued on pages 180 and 181)

tended 23 different out-of-state colleges or universities.

Applications were sent to 309 West Virginians and 174 non-residents, and were returned by 202 West Virginians and 125 non-residents. Interviews were granted by the 20-member Committee on Admission to all state applicants and to 53 from out-of-state.

The 84 West Virginians come from 31 counties. Monongalia County is listed as home for 14; Kanawha has 12 and Cabell 11.

Members of the class, with county and town of residence indicated, include:

*Barbour:* Philippi — Roger K. Myers.

*Berkeley:* Martinsburg — Joseph P. Catlett.

*Braxton:* Ireland — Ricky L. Singleton.

*Brooke:* Wellsburg — Stephen J. Freshwater and John A. Leon.

*Cabell:* Barboursville — Jerry L. Frame; Huntington — Jeffrey E. George, Faith E. Hyman, Gregory T. Lagos, Richard F. Loeser, Jr., Gary L. Matheny II, Samuel S. Newman, Matthew D. Ohl, Brenda C. Peart, Roger A. Ray and Ralph W. Webb.

*Doddridge:* West Union — Robert E. Heflin II.

*Fayette:* Charlton Heights — Karl L. Yang.

*Hampshire:* Three Churches — Joel T. Van Sickler.

*Hancock:* Newton — Jeffrey B. Sinclair; Weirton — David P. Paar.

*Harrison:* Bridgeport — David A. Faris; Clarksburg — Walter S. Stalenski and Ann Lee Thrush.

*Jefferson:* Shepherdstown — Janice L. Butcher.

*Kanawha:* Charleston — Lucy M. Biddle, Susan L. Cavender, Semele Foundas, Carol L. Johnson, Medard L. Lefevre, Jr., Steven B. Lippitt, Thomas J. Murphy, Michael G. Nunley, Larry A. Rhodes and Frederick H. Weidman; Dunbar — Robin L. Harless; South Charleston — William S. Ketcham.

*Logan:* Logan — Steven A. McCormick.

*Marion:* Fairmont — David H. Hauge.

*Marshall:* Glen Dale — Melinda J. Elliott.

*McDowell:* Bradshaw — Edward B. Jones; Welch — Robert D. Groseclose.

*Mercer:* Athens — Patricia Freedlander.

*Mineral:* Patterson Creek — Russell F. DeVore; Ridgeley — Terry W. Capel and Robin L. Harman.

*Monongalia:* Morgantown — M. Patrick Allender, Dona M. Alvarez, Dirk C. Davidson, Mary J. Gantzer, Valerie A. Lazzell, John R. Meek, Charles A. Moore, David B. Peden, James M. Shreve, Thomas E. Thrush, Timothy P. Weyrich and Frederick A. Zeller; Westover — Keith A. Knupp and Beth E. Levine.

*Nicholas:* Mt. Nebo — William D. Ramsey.

*Ohio:* Triadelphia — Sorin J. Brull; Wheeling — Grace N. Cater, William A. Dalzell, Lorraine M. Hahn, Thomas A. Kopitnik, Susan B. Pratt and Frank J. Trupo.

**Dr. Hoyt D. Gardner (second from left) of Louisville, Kentucky, President of the American Medical Association, was special guest speaker for the annual Family Physicians Dinner held recently by the Department of Family Practice, Weirton Medical Center. Also shown are, from left, Dr. Richard E. Flood of Weirton, a Delegate of the State Medical Association to the AMA; Dr. Daniel B. Crowder, President, West Virginia Northern Community College, Weirton; Dr. Pedro R. Montero, Jr., of Weirton, Co-Chairman for the dinner; Dr. Eli J. Weller, Weirton, Chairman Department of Family Practice, Weirton Medical Center, and Dr. Stephen D. Ward, Wheeling, President of the State Medical Association.**

*Pendleton:* Cherry Grove — John K. Seegar.

*Pleasants:* St. Marys — Norman C. Mitchell.

*Putnam:* Hurricane — Terry L. Good.

*Raleigh:* Beckley — Mark R. McGinnis.

*Randolph:* Elkins — Paula J. Brake.

*Roane:* Spencer — Edward D. Lane.

*Summers:* Pence Springs — Mary A. Young.

*Tyler:* Friendly — William G. Bell.

*Upshur:* Buckhannon — Larry M. Lantz, Jeffrey S. Neal and Robin A. Rodeheaver.

*Wood:* Parkersburg — Robert V. Blair, Steven A. Cremer, Frederick L. Gottlieb and Elaine M. Kimmel; Vienna — James P. Anderson.

*Out-of-State:* New York, West Babylon — Salvatore Parascandola; Ohio, Steubenville — George J. Kellis; Tallmadge — Iakshmikumar Pillai; Pennsylvania, Smock — Joseph M. Labuda II.

## Malignant Melanoma Symposium July 12 In Charleston

A course, "Oncology Symposium on Malignant Melanoma," will be held on Thursday, July 12, at the West Virginia University Medical Center Education Building, 3110 MacCorkle Avenue, S. E., Charleston.

The program will begin at 8 A. M. and adjourn at 1:30 P. M. following lunch served in the Student Lounge.

The workshop objectives are for participants to recognize the current status of melanoma in West Virginia; to identify malignant melanoma and its specific pathological findings, and to understand the role of chemotherapy, systemic therapy and surgery in the treatment of melanoma.

Sponsors are the Department of Surgery of the Charleston Area Medical Center (CAMC) and the Charleston Division/WVU Medical Center.

The speakers and their topics will be "Malignant Melanoma and Differential Diagnosis" — Stephen K. Milroy, M. D., Charleston Dermatologist; "The Pathological Findings in Melanoma" —Graciano E. Cendana, M. D., Chief, Surgical Pathology, CAMC, and Clinical Associate Professor of Surgery, Charleston Division/WVU Medical Center;

"Surgical Considerations in Melanoma" — James P. Boland, M. D., Professor and Director, Department of Surgery, Charleston Division/WVU Medical Center; "Regional Perfusion with Hyperthermia and Chemotherapy for Malignant Melanoma"—Carl Sutherland, M. D., Associate Professor of Surgery, Tulane University School of Medicine;

"Melanoma in West Virginia" — Kenneth Scher, M. D., Assistant Professor of Surgery, Marshall University School of Medicine, and "Systemic Therapy for Malignant Melanoma"—Doctor Sutherland.

The program is open to all interested health professionals. For registration and other information, telephone the Conference Coordinator at (304) 347-1242.

## New MU Medical School Class Of 36 Named

Marshall University's School of Medicine recently announced admission of a 36-member Class of 1984 which exceeds both the national and state norms for overall academic grade point average (GPA).

"Obviously we are extremely pleased with the potential shown by this group of 28 men and eight women who will begin their medical studies in September," Dr. Robert W. Coon, MU Medical School Dean, said.

According to statistical data compiled by the School's admissions officer, Cynthia Warren, the Medical School's class of 1984 has a mean GPA of 3.6 on a 4.0 scale.

A recent American Medical College Application Service (AMCAS) Admissions Action Summary shows the overall mean for the more than 15,500 students accepted into medical school this fall nationally to be 3.54. The statewide mean for West Virginia students is 3.55.

"In view of the recent criticism regarding the scholastic quality of students admitted to West Virginia medical schools, I think it is important to point out that our students more than meet the national norm," Doctor Coon said.

The new class includes 34 West Virginia residents and one each from Lawrence County, Ohio, and Greenup County, Kentucky. Two sets of brothers—Joseph Mark and Paul Victor Kowalski of Huntington, and Boutros W. and Michael W. Istfan of Poca—were admitted. The class also contains two veterans, Daniel David Sumrok, Jr., of Morgantown and Gregory Mark Moreland of Huntington.

Other members of the class are: Jimmy Vernon Wolfe, French Creek; Maudie Lee Adkins, Wayne; James William Banks III, Union; Timothy David Canterbury, Daniels; Arlie Matthew Ellison, Nimitz; Donna Ruth Gates, Welch; Michael Eugene Gaudio, Follansbee; Kathleen Ellen

Lucas, Morgantown; Thomas Brennan Maloney, Wheeling; David Ray Nunley, Sissonville; Clifford Douglas Phillips and Evelyn Ray Rector, Elkins;

Charles Porter Stuckey, Martinsburg; Jill Scott Vargo, Oak Hill; Susan T. Wells, Weirton; Jeffrey Wayne Whightsel, South Charleston; David Keith Calvert, Christopher John Whitten and Arthur Hunter Wilson, Charleston; Harold Edward Ayers, Jr., Mark Allen Byard, Robert Thomas Gallaher, Perry Meadows, Bobby Anderson Miller II, Louis Rafael Molina, Brenda Carol Peart and Matthew Alan Rohrbach, Huntington; Marsha Lee Bailey, Dunbar; Daniel Lee Hall, Worthington, Kentucky, and Robert Albert Hess, Proctorville, Ohio.

Class members range in age from 20 to 30, with an average age of 23.1. The students' undergraduate schools include Marshall, West Virginia University, West Liberty State College, West Virginia State College, Wheeling College, West Virginia Wesleyan College and Alderson Broaddus College. Also represented in the class are the following institutions: Baylor University, University of Kentucky, Florida State University, University of Virginia, Virginia Polytechnic Institute and Washington University.

Marshall received 498 applications from prospective medical students, according to the school's admissions officer. Personal interviews were conducted with 170 applicants, of whom 147 were state residents, Ms. Warren said.

## VA Appoints MU Medical Dean To Advisory Group

Dr. Robert W. Coon, Vice President for Health Sciences at Marshall University and Dean of the School of Medicine, has been appointed to the U. S. Veterans Administration's 25-member Special Medical Advisory Group (SMAG).

Nominated by Dr. Donald L. Custis, Chief Medical Director of the VA, Doctor Coon was named to a four-year term on the special committee by U. S. Veterans Affairs Administrator Max Cleland.

Created in 1945 by Congress as an outgrowth of the Veterans Bureau Medical Council, SMAG is an advisory agency designed to provide VA officials with input on health care and treatment of veterans. The Committee also provides counsel to the Administrator and Chief Medical Director on the awarding of VA research grants and on affiliation agreements and assistance grants to medical schools and other health manpower training institutions.

# *Medical Meetings*

July 14-16—NIH Consensus Development Conference on Adjuvant Chemotherapy of Breast Cancer, Bethesda, Md.

July 20-24—AMA House, Chicago.

July 23-25—NIH Consensus Development Conference on Cervical Cancer Screening: The Pap Smear, Bethesda, Md.

Aug. 7-8—2nd Annual Sports Med. Clinic (MCV), Richmond, Va.

Aug. 10-14—Sixth Western Hemisphere Nutrition Conference, Los Angeles.

**Aug. 20-23—113th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.**

Sept. 3-6—Am. Assn. of Obstetricians & Gynecologists, Hot Springs, Va.

Sept. 4-5 — Diagnostic Ultrasound in Obstet.-Gynecol., Johns Hopkins, Baltimore.

Sept. 8—William E. Irons, M. D., Surgical Symposium, Huntington.

Sept. 8-10—Am. Neurological Assn., Boston.

Sept. 11-12—40th Annual Congress on Occupational Health of the AMA, Salt Lake City.

Sept. 21-25—Am. College of Radiology, New Orleans.

Sept. 27-29—Drug in Medical Practice (AMA theme meeting), Kansas City, Mo.

Sept. 28-Oct. 3—Am. Society of Plastic & Reconstructive Surgeons, New Orleans.

Oct. 6-9—AAFP, New Orleans.

Oct. 9-11—Am. Cancer Society, Los Angeles.

Oct. 10-12—Pediatric Approach to Common Neurological Problems (Johns Hopkins), Ocean City, Md.

Oct. 17-19—AMA Regional Meeting, Huron, Ohio.

Oct. 19-24—ACS Clinical Congress, Atlanta.

Oct. 24-26—AMA Regional Meeting, Philadelphia.

Oct. 26-30—Am. College of Chest Physicians, Boston.

Oct. 29-Nov. 1—Fourth National Conference on the Impaired Physician (AMA, Med. & Chirurgical Faculty of Md.), Baltimore.

Nov. 2-7—Am. Academy of Ophthalmol., Chicago.

Nov. 12-15—Am. Heart Assn., Miami.

Nov. 13-15—A National Forum on Comprehensive Cancer Rehabilitation and its Vocational Implications (Va. Dept. of Rehabilitative Services, MCV), Williamsburg, Va.

Nov. 14-16—AMA Regional Meeting, New York City.

**1981**

**Jan. 23-25—14th Mid-Winter Clinical Conference, Charleston.**

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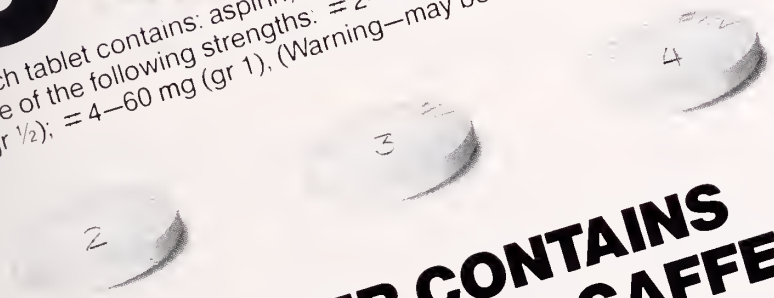


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# WVU Medical Center
# –News–

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## Awards Convocation Honors Students, Teachers

Twenty-two students and two faculty members in the West Virginia University School of Medicine were honored for their achievements at the annual awards convocation this spring.

Donald R. Lilly of Martinsburg was chosen by his senior classmates for the Upjohn Award based on applied personal qualities including character and leadership. The award consists of an engraved plaque and a $150 prize.

Cynthia O. Jopling of Morgantown, a senior in the Division of Physical Therapy, was winner of the E. J. Van Liere Award, an engraved medal and $100. Her project was judged best in the annual student research convocation.

The William Bennett Prize in Anesthesiology, given for the first time this year, was awarded to Michael W. Jopling, a senior from Elkview. This prize of $100 is in memory of a member of the senior class who died in December as the result of an automobile accident.

The MacLachlan Award, an engraved plaque provided by the school's alumni association and given to an outstanding teacher chosen by the sophomore class, was presented to Donald C. Carter, M.D. Doctor Carter is Professor of Behavioral Medicine and Psychiatry.

Winner of the Clinician of the Year Award for excellence in clinical teaching was Michael E. Crouch, Assistant Professor of Medicine. He was chosen by members of the senior class to receive the engraved plaque.

Other awards and winners were:

Edward G. Stuart Memorial Award to the senior who "best exemplifies the qualities of empathy and understanding and strengthens competence with compassion," James K. Porterfield of Martinsburg. The award includes a plaque, desk clock and $25.

Lindsay Memorial Award for outstanding performance in physiology, Michael E. Cunningham, a second-year student from Paden City.

Anido Award for outstanding academic achievement in laboratory medicine by a second-year student. Barbara A. Clark of Weirton.

CIBA Award for involvement with the American Medical Students Association and in organization of the holistic medicine seminars along with continued interest in community service, J. Michael Peterson, a sophomore from Charleston.

Merck Manual Award for scholastic achievement, seniors Richard M. Allman of Parkersburg and Stanley T. Day of Morgantown.

Lange Book Awards for scholarship: seniors Porterfield and Tony R. Zerbe of Washington (Wood County); juniors Thomas W. Croghan of Clarksburg and Deborah F. Dickert of South Charleston; sophomores David Cheney of Philippi and Ms. Clark; and freshmen Gary J. Renaldo of Fairmont and Daniel W. Wilson of St. Marys.

Mosby Book Awards for scholarship, sophomores Cunningham, Ronald L. Gross of Huntington and Brenda L. Holbert of Morgantown.

American Medical Women's Association scholarship Achievement Citations to honor graduates: Rita W. Arbuckle of Lewisburg, Jane W. Riester of Morgantown, Joan G. Potter of St. Albans and Mari M. Yambor of Fairmont.

## Alumnus Heads Society

A WVU School of Medicine alumnus has been elected President of The Society of Teachers of Family Medicine.

Eward J. Shahady, M.D., Professor and Chairman of the Department of Family Practice at the University of North Carolina School of Medicine at Chapel Hill since 1976, assumed the presidency of the 1800-member organization at its recent annual spring conference in Boston. Doctor Shahady, who grew up in Fairmont and completed his undergraduate education at Wheeling College, earned his medical degree in 1964 from WVU.

# WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*

## A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

# EQUAGESIC® ©IV

## (meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

*INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

**CONTRAINDICATIONS**: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

**WARNINGS**: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

**USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.**

**Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.**

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

**PRECAUTIONS**: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

**ADVERSE REACTIONS**: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and, possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

**OVERDOSE**: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

**DESCRIPTION**: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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# FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed

# WHY NOT WYGESIC® CIV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

**WYGESIC—Abbreviated Summary**

**INDICATION:** For the relief of mild-to-moderate pain.

**CONTRAINDICATION:** Hypersensitivity to propoxyphene or to acetaminophen

**WARNINGS:** CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Menegement of Overdosege**)

**DRUG DEPENDENCE:** Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

**USAGE IN AMBULATORY PATIENTS:** Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g driving a car or operating machinery Patients should be cautioned accordingly

**USAGE IN PREGNANCY:** Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

**USAGE IN CHILDREN:** Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group

**PRECAUTIONS:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

**ADVERSE REACTIONS:** The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported

**DRUG INTERACTIONS:** Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

**MANAGEMENT OF OVERDOSAGE:** SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal

**TREATMENT:** Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and/or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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# Third-Party News, Views and Program Concerns

## Planners May Be In Violation Of Antitrust Laws

The Justice Department has told Virginia health planners that some health planning agreements may be a violation of the federal antitrust laws.

The case involves a proposal to encourage Richmond, Virginia, hospitals to take cooperative steps to reduce obstetric services.

The Central Virginia Health Systems Agency was told by the Justice Department that such proposed joint action might come under the shadow of the antitrust laws unless specifically approved by Congress or state legislatures.

The advisory Justice Department letter has national implications on health planning activity and may force Congress to take another look at the wording of the law, observed the American Medical Association. The comment was termed a "very serious development that would run directly contrary to what the Congress intended," by the American Health Planning Association.

A Richmond hospital group had challenged the obstetric proposal, claiming it could inhibit competition and new services. As a result, the Justice Department was asked to express its views.

The problem was bound to arrive sooner or later since health planning decisions often run contrary to the assumptions of a competitive health marketplace, the AMA commented.

## Questions Approval Requirement To Reduce Beds, Services

Facilities planning to reduce bed capacity or services should not have to seek certificate-of-need approval by planning authorities, the American Medical Association has told the U.S. Health and Human Services Department.

Commenting on proposed regulations to carry out changes in the planning law, the AMA said "such application of the certificate-of-need program could force an institution to keep beds and maintain a service even though it might deem it inappropriate and infeasible to do so. This would seem to be holding the institution in bondage."

Congress' concern in the planning law was increases, not decreases, the AMA noted.

Also questioned by the AMA was the wording of the new regulation extending certificate-of-need to purchase of expensive equipment (more than $150,000) for physicians' offices if the equipment is designed in large part for use by hospital inpatients. The requirement for "irregular" use only for inpatients is too inflexible since it would apply to such cases as an agreement with a hospital to use the office equipment when the hospital equipment is undergoing regularly scheduled maintenance, the AMA said.

The AMA said it was "strongly concerned" with a requirement that the state planning agency consider the quality of care in an institution as an element in certificate-of-need determination. The actual determination of quality should be resolved by agencies such as the Joint Commission on Accreditation of Hospitals, state licensing authorities, and professional standards review organizations, said the AMA.

## Federal Budget Cuts Could Compromise Health

Proposed federal budget cuts in health funding are so severe that they could compromise the health of the American people, the American Medical Association declares.

In a recent statement to the House Appropriations Committee of the Congress the AMA stated:

"While we recognize that governmental priorities must be established and that certain programs must be cut, we believe that other programs should be strongly supported if the health needs of the American people are to be met. We urge this Committee to consider carefully any reductions in federal funding that might compromise the health of the American people."

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# Obituaries

### ARTHUR E. McCLUE, M. D.

Dr. Arthur E. McClue of Dunbar (Kanawha County), a former State Health Commissioner, died on May 22 in a South Charleston Hospital. He was 81.

Doctor McClue served as Health Commissioner from 1933 to 1941. He practiced in New Cumberland (Hancock County) before becoming Commissioner. He later set up practice in Dunbar, retiring six years ago.

A veteran of World War I, he was a graduate of West Virginia University and received his M. D. degree in 1925 from the University of Louisville School of Medicine.

Doctor McClue was an honorary member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow and two daughters, Mrs. Mary Margaret Dennis of Dunbar and Mrs. Elouise Lynch of Oakhurst, California.

### W. BECKETT MARTIN, M. D.

Word recently was received by *The Journal* of the death of Dr. W. Beckett Martin, Huntington dermatologist, on March 19 in a hospital there. He was 74.

A native of Huntington, he had practiced there since 1932.

Doctor Martin, a veteran of World War II, received his M. D. degree in 1930 from Emory University School of Medicine in Atlanta, Georgia. He interned at the former Chesapeake & Ohio Hospital in Huntington and in Atlanta, and also completed postgraduate work in New York City.

Doctor Martin was a member of the Cabell County Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow; a son, James E. Martin of Worthington, Ohio; a daughter, Mrs. Alan Garges of Ashland, Kentucky, and three sisters, Mrs. Guy Jackson of Ashland, Mrs. Alva Ball of South Charleston and Mrs. George Kirchner of Huntington.

(Continued On Page xix)


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A. M. Fuller, M. D.
F. A. Khan, M. D.

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H. E. W. Gregor, M. D.

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J. J. Rizzo, M. D.
M. W. Strider, M. D.

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D. R. Antonio, M. D.

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R. J. Haas, M. D.

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C. P. O'Sullivan, M. D.

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W. B. Blum, M. D.
B. R. Blackburn, M. D.
R. A. Rose, M. D.

**UROLOGY:**
D. T. Chua, M. D.

# County Societies

### MARION

The Marion County Medical Society met on April 29 at the Fairmont Field Club.

The guest speaker was Lt. Col. Edward Traumntout, M. D., Chief of Infectious Diseases at Walter Reed Army Medical Center. His topic was "Gram Negative Sepsis." — William L. Mossburg, M. D., Secretary.

* * *

### McDOWELL

Dr. David G. Borenstein of Washington, D. C., was guest speaker for the meeting of the McDowell County Medical Society on May 14 at Stevens Clinic Hospital in Welch.

Doctor Borenstein, Assistant Professor of Medicine, Division of Rheumatology, George Washington University Medical Center, talked on "Current Concepts in the Therapy of Common Arthritic Conditions."

Another guest was John C. Whitmore, Senior Professional Representative of Merck Sharp & Dohme, who arranged the scientific program. — Muthusami Kuppusami, M. D., Secretary.

* * *

### MINGO

The Mingo County Medical Society met on May 14.

Special guests were Mr. Sol Liss and Mr. Merrill Perry, who demonstrated pain suppressor devices. These devices are non-invasive and have

(Continued On Page xix)


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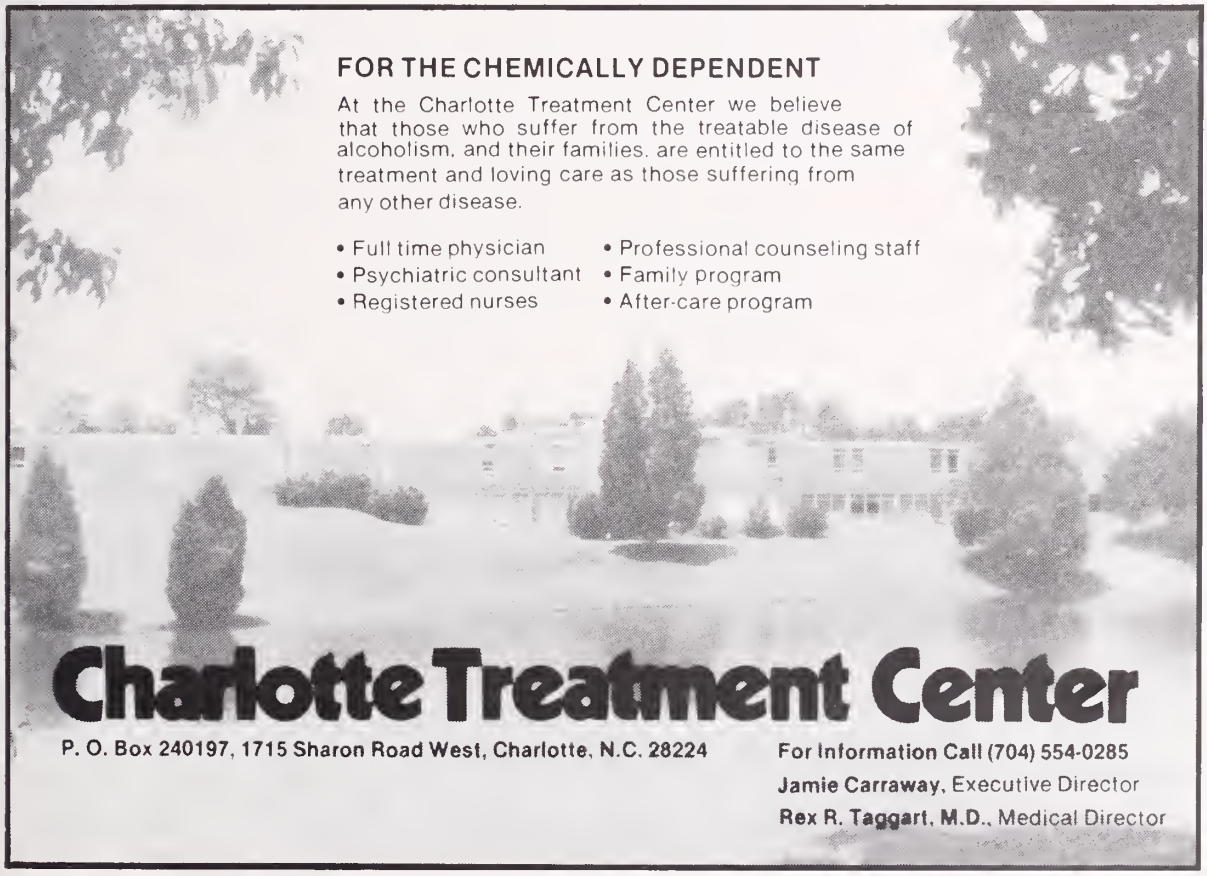

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Brief Summary

**INDICATION** Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS** Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma, Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors (hypertensive crises may result).

**WARNINGS** If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy.* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children.* Tenuate is not recommended for use in children under 12 years of age.

**PRECAUTIONS** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

**ADVERSE REACTIONS** *Cardiovascular.* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System.* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal.* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic.* Urticaria, rash, ecchymosis, erythema. *Endocrine.* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System.* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous.* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSAGE AND ADMINISTRATION** Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSAGE** Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc
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*Direct Medical Inquiries to*
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**References** 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon (Dillon), R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed. New York: Raven Press, 1978, pp. 391-404.

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Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. 4 so encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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**RICHARD E. LEWIS, M. D.**

Dr. Richard E. Lewis of St. Clairsville, Ohio, died on April 23 in a Wheeling Hospital. He was 53.

Doctor Lewis was a pediatrician with the Wheeling Clinic at its St. Clairsville Clinic.

A native of Wheeling, he was graduated from Ohio Wesleyan University and received his M. D. degree in 1954 from Case Western Reserve University School of Medicine. He interned at Grasslands Hospital in Valhalla, New York, and took his residency at Babies & Childrens Hospital in Cleveland.

A veteran of World War II, Doctor Lewis was a member of the Belmont County (Ohio) Board of Health.

He was a member of the Ohio County Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow; two sons, James W. and Bruce R. Lewis, at home; a daughter, Mary E. Lewis, at home; a brother, Dr. Robert N. Lewis of St. Clairsville, and a sister, Elizabeth Spurrier of Daytona Beach, Florida.



no known side effects. Research on pain suppression was discussed, and questions were answered by Mr. Liss and Mr. Perry.

Mr. Alan Tenthoff of the West Virginia Division of Vocational Rehabilitation also was a guest. Mr. Tamerof is especially interested in hearing problems. He outlined his Department's available services and the necessary methods of asking for the services.—Arthur E. Levy, M. D.

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**WANTED** — Obstetrician/Gynecologist needed to take over existing practice in progressive community centrally located between Parkersburg and Charleston. Nine year old modern 80 bed hospital with latest equipment and facilities. Hospital is willing to negotiate financial arrangements and office space. Excellent opportunity for young physician wishing to establish active practice. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

**ANESTHESIOLOGIST:** Needed to join a small, busy private hospital located in Mullens, West Virginia. Excellent opportunity for partnership. Income guaranteed or percentage of fee for services. Contact F. J. Zsoldos, M. D., Wyoming General Hospital, Box 548, Mullens, West Virginia or Call 294-4940 Collect.

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**GENERAL PRACTITIONER:** Urgently needed, primary care physician or General Practitioner with West Virginia license to work immediately in busy general hospital in Mullens, West Virginia, and to be associated with hospital and clinics. Salary open or can work out arrangements fee for service. Contact F. J. Zsoldos, M. D., Box 548, Mullens, West Virginia or call 294-4940 Collect.

**FOR SALE OR RENT**—Physician's office building with 1500 square feet, near new hospital, central location, good medical climate, schools, roads and recreation. Also one lot of used equipment, including exam tables, treatment tables, scales, otoscopes, microscopes, desk, etc. Sell as a lot only, priced at $3,500 firm. If interested write W. W. Huffman, M. D., 610 Braxton Street, Gassaway, WV 26624.


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**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician for 9 year old modern 80 bed hospital centrally located between Parkersburg and Charleston. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

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**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician for a modern 95-bed hospital. New emergency room facilities recently built. Excellent working conditions. Contact Patrick Smith, Assistant Administrator, Summers County Hospital, Hinton, WV 25951. Telephone: (304) 466-1000.

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**WANTED**—Board eligible or certified Obstetrician Gynecologist needed for small town of 6,000. Modern hospital with latest equipment to work with available. Financial arrangements and office space negotiable. Contact J. N. Vallandingham, Administrator, Summers County Hospital, Hinton, WV 25951. Telephone: (304) 466-1000.

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**EMERGENCY ROOM PHYSICIAN** — Immediate opening for an emergency room physician to join a young, progressive E. R. group in southern West Virginia. Individual would join R. M. Cyphers, M.D. (West Virginia University Medical School, class of '72), at a 215-bed community hospital located in Princeton. Guaranteed income and excellent working conditions are available. Please contact Bill Clark, Associate Administrator, Princeton Community Hospital, Princeton, WV 24740. Telephone: (304) 425-2434.

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Eye & Ear Clinic of Charleston, The xv

Golden Clinic, The xvi

Harding Hospital, The xxii

Kanawha Valley Bank, N. A. xix

Lilly, Eli, and Company x

McDonough Caperton Shepherd Association Group ix

Merck Sharp & Dohme *Insert*

Merrell-National, Inc. vi, *Insert*, xviii, *Insert*

Myers Clinic, The xviii

Pathology Associates Laboratory vii

Prince Medical Reference Laboratories xiii

Roche Laboratories ii, iii, iv, *Inside Back Cover*, *Back Cover*

Saint Albans Psychiatric Hospital xv

United States Air Force viii

United States Navy xviii

Wheeling Clinic, The xx

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**Contraindicated:** Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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# The West Virginia Medical Journal

*Official Publication of the West Virginia State Medical Association*

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**ISSN 0043 - 3284**

# CONTENTS

## Scientific Articles

Management of Gastroschisis—J. Barry Boyd, M. D.; Ellen E. Hrabovsky, M. D.; and Alvin L. Watne, M. D. 183

Hospital Mortality in 342 Hip Fractures—Lance Matheny II, Thomas F. Scott, M. D.; Colin M. Craythorne, M. D.; Robert W. Lowe, M. D.; and John O. Mullen, M. D. 188

The Management of Grief—William H. Nelson, M. D. 191

## The President's Page

Reflections on a Year—Stephen D. Ward, M. D., President, W. Va. State Medical Association 196

## Editorials

Very Good Year 197

A Fierce Pride and Dedication 198

True Advocacy 199

## General News

Complete Plans for 113th Annual Meeting 200

Huntington Symposium Speakers Named 204

Association Names Scholarship Winners 205

Auxiliary Completes Meeting Plans 206

Amendments up for House Action 208

MU Schedules Geriatric Program 208

Convention Program 211

A Word of Thanks 214

Program Committee 215

Delegates and Alternates 216

Auxiliary Program 218

Scientific Exhibit 220

Annual Reports 222

## Special Departments

WVU Medical Center News x

Third-Party News, Views, Program Concerns xii

Obituaries xiv

County Societies xv

Classified Section xviii

Index To Advertisers xx

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AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

**INDICATION** Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

**CONTRAINDICATIONS** Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

**WARNINGS** If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis often clinically indistinguishable from schizophrenia. *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children* Tenuate is not recommended for use in children under 12 years of age.

**PRECAUTIONS** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

**ADVERSE REACTIONS** *Cardiovascular* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic* Urticaria, rash, ecchymosis, erythema. *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSAGE AND ADMINISTRATION** Tenuate (diethylpropion hydrochloride) One 25 mg tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSAGE** Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc
Cayey, Puerto Rico 00633

*Direct Medical Inquiries to*
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A.

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**References** 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed. New York: Raven Press, 1978, pp. 391-404.



**Merrell**

9 4672 (Y957A)

# Overweight may not always be simple... complications can develop.*

# Complicated or not...

# Tenuate® Dospan® ©IV

## (diethylpropion hydrochloride NF)

**75 mg. controlled-release tablets**

### A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

### In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

### Clinical effectiveness.

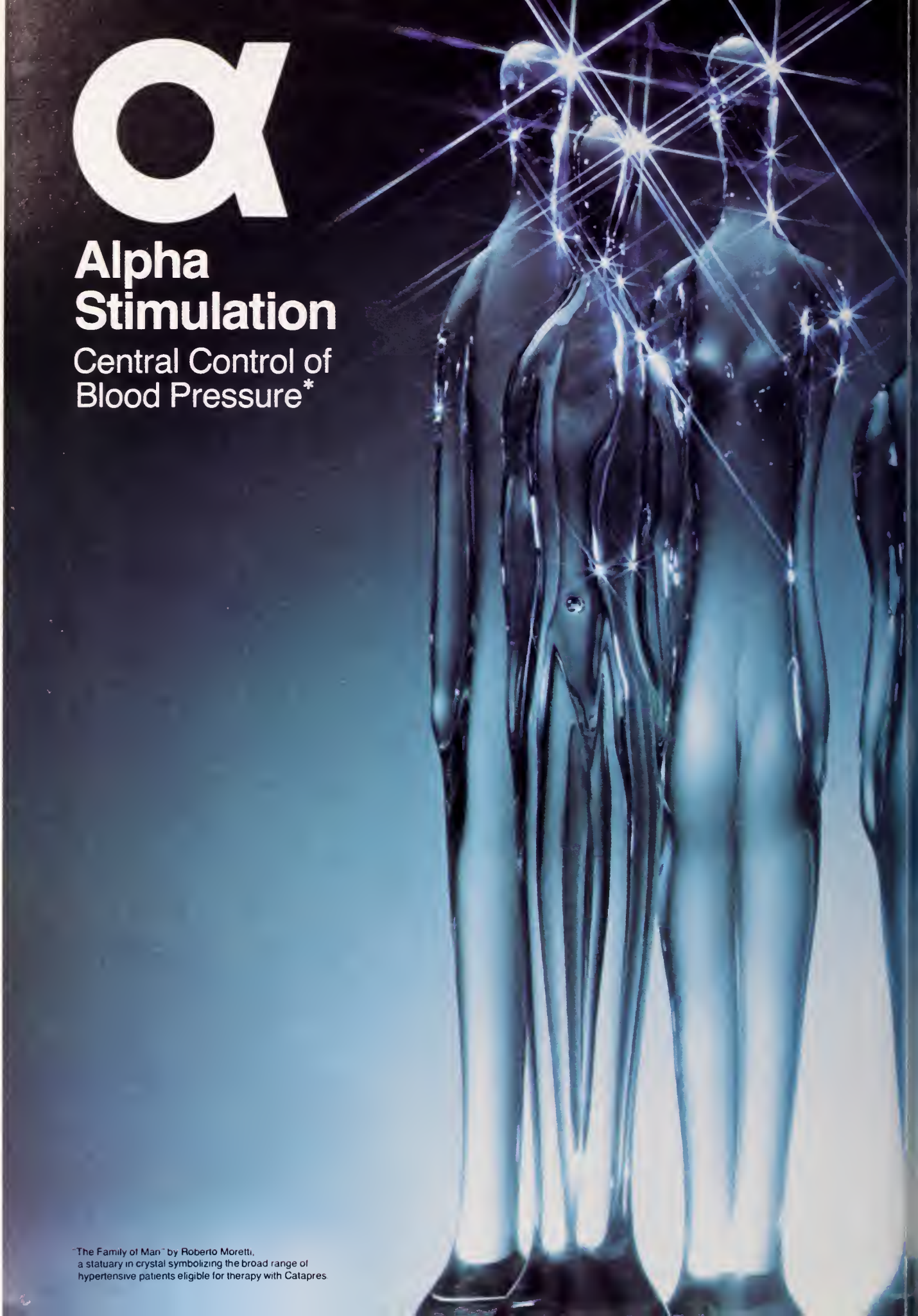
The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

## Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

**Merrell**

For prescribing information see opposite page.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"The Family of Man" by Roberto Moretti, a statuary in crystal symbolizing the broad range of hypertensive patients eligible for therapy with Catapres.

# The Alpha Advantage:

## It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

| | |
|---|---|
| Congestive heart failure | Allergic rhinitis |
| Ventricular hypertrophy | Hepatic disease |
| Hyperglycemia | Hyperuricemia |
| Diabetes mellitus | Gouty arthritis |
| Bronchial asthma | Sulfonamide hypersensitivity |

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

**work/play**—normal hemodynamic responses to exercise maintained.

**love**—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

**cardiac output**—tends to return to control values during long-term therapy.

**blood flow**—preserved in kidney.

*No Single Advantage Determines Drug Choice.*

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1 Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

**Now available in new 0.3 mg tablets**

Tablets of 0.1, 0.2, 0.3 mg

# Catapres®
## (clonidine HCl)
## Hypertension

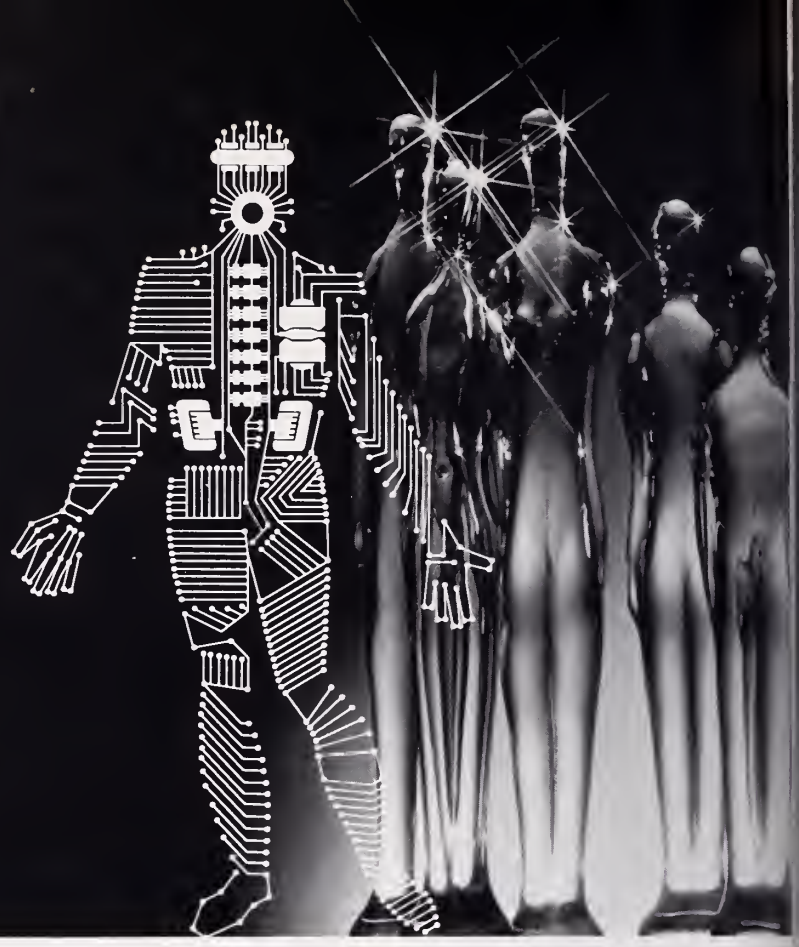
# The Alpha Advantage:

## It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

**Catapres®**
(clonidine HCl)

**Hypertension**



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at bre fast and 0.1 mg at bedtime. Some patients may ber from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

**Catapres®**
**(clonidine hydrochloride)**
**Tablets of 0.1, 0.2, 0.3 mg**

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
*Usage in Children:* No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 m longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsir sedation. Constipation, dizziness, headache, and fatigue have been r Generally these effects tend to diminish with continued therapy. The f reactions have been associated with the drug, some of them rarely ( instances an exact causal relationship has not been established.) These Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnorm liver function tests; one report of possible drug-induced hepatitis withou and hyperbilirubinemia in a patient receiving clonidine hydrochloride thalidone and papaverine hydrochloride. Weight gain, transient elevation glucose, or serum creatine phosphokinase: congestive heart failure, Ra phenomenon; vivid dreams or nightmares, insomnia, other behavioral c nervousness, restlessness, anxiety and mental depression. Also ra gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not as with a rash, impotence, urinary retention, increased sensitivity to alcohol, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gyneco weakly positive Coombs' test, asymptomatic electrocardiographic abno manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminishe sent reflexes and vomiting followed the accidental ingestion of Catapres ( hydrochloride) by several children from 19 months to 5 years of age. lavage and administration of an analeptic and vasopressor led to com covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 3 intervals usually abolishes all effects of Catapres, (clonidine hydrochloric dosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1 available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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# An added complication... in the treatment of bacterial bronchitis*

**Brief Summary.**
**Consult the package literature for prescribing information.**

**Indications and Usage**: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

*Lower respiratory infections*, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

**Contraindication**: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

**Warnings**: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

**Precautions**: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

*Usage in Pregnancy*—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

*Usage in Infancy*—Safety of this product for use in infants less than one month of age has not been established

**Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]**

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

**Ceclor®**
**cefaclor**
Pulvules®, 250 and 500 mg

**Adverse Reactions:** *In* clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below

*Gastrointestinal* symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90)

*Hypersensitivity* reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients

*Other* effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

*Causal Relationship Uncertain*—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

*Hepatic*—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

*Hematopoietic*—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

*Renal*—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [0703794

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

*Note*: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

**References**


1 Antimicrob. Agents Chemother., *8*: 91, 1975
2 Antimicrob. Agents Chemother., *11*: 470, 1977
3 Antimicrob. Agents Chemother., *13*: 584, 1978
4 Antimicrob. Agents Chemother., *12*: 490, 1977
5 Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978
6 Antimicrob. Agents Chemother., *13*: 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Bennett), p. 487. New York: John Wiley & Sons, 1979


*Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285*

**Eli Lilly Industries, Inc.**
Carolina, Puerto Rico 00630

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The West Virginia Medical Journal

Vol. 76, No. 8 August, 1980

# Management Of Gastroschisis*

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*A review of the history of the development of the surgical treatment of gastroschisis is presented. The results of nine patients managed over two years are reviewed. Recommendations for improved survival are outlined, including expansion of the defect, early closure, ventilatory support and intravenous alimentation.*

Gastroschisis is a neonatal emergency. Improvements in surgical management have improved survival, but a significant mortality rate still exists. This paper reviews the history of the development of the surgical treatment of gastroschisis. The embryology and clinical presensation are briefly reviewed to clarify the problem. The results of nine patients treated over two years are reviewed, and our recommendations for treatment are outlined.

### History

The word, gastroschisis, is derived from Greek, meaning "belly cleft." Until recently gastroschisis was felt to be a rare and fatal condition. Bernstein reported one of the earliest cases in the literature in 1940.[1] The first successfully-treated case was managed by primary closure and reported by Watkins in 1943.[2]

Primary closure resulted in a high mortality rate secondary to respiratory insufficiency. Moore and Stokes reported on two successful cases treated by skin flap closure in 1953[3] (a modification of the method developed by Gross in 1948 for correction of omphalocele).[4] Skin flap closure required multiple staged procedures and resulted in significant wound complications and mortality.

Schuster, in 1967, described a new method using silastic sheeting to cover large omphaloceles.[5] Shortly thereafter, several series were reported using the silo technique to repair gastroschisis.[6-7] Significant wound complications and mortality secondary to sepsis resulted. Recent review by Rubin and Ein in 1976 and Aaronson and Eckstein in 1977 reported mortality rates of 35 per cent and 47 per cent with silo repairs.[8-9]

Amoury, Ashcraft and Holder recently reviewed the complex problem of gastroschisis associated with intestinal atresia.[10] In a review of 200 cases, 13 per cent had atresias. There was a 66 per cent survival rate without atresia and a 28 per cent survival with atresia. Multiple procedures have been attempted including bypass, resection with anastomosis, and preliminary enterostomy with secondary anastomosis. Primary resection with anastomosis was recommended when feasible.

Other recent advances in surgical management have improved survival in gastroschisis. These include advances in antibiotics, mechanical ventilatory support and intravenous nutrition.

### Embryology and Clinical Presentation

Anomalies of the abdominal wall occur in approximately one in 5,000 live births. A brief review of the embryology of the abdominal wall and the clinical presentation of gastroschisis is

*This article, which was awarded a prize for a paper by a resident, was presented during the meeting of the West Virginia Chapter, American College of Surgeons, May 3-5, 1979, at the Greenbrier, White Sulphur Springs, West Virginia.

necessary for proper recognition and management.

The splanchnic layer of the germinal disc develops into the visceral organs, and the somatic layer becomes the body wall. The thoracic and epigastric walls develop from the cephalic fold of the germinal disc. The hypogastric wall and allantios develop from the caudal fold. The lateral walls of the abdomen are formed from the lateral body wall folds. The folds converge by the fifth embryonic week to form the umbilicus. Failure of convergence results in an omphalocele. A different type of deformity, such as ectopia cordis, gastroschisis, or exstrophy of the bladder may result from failure of differentiation of the mesenchyme of the abdominal fold with resorption of the ectoblastic layer.

As noted above, gastroschisis and omphalocele seem to evolve from separate developmental abnormalities. The recognition and differentiation of the two entities are important in that the surgical management and associated anomalies are different. Moore recently reviewed the clinical differences between gastroschisis and omphalocele.[11] Patients with gastroschisis have a much higher incidence of prematurity but fewer associated anomalies. Omphalocele patients have a higher incidence of other anomalies including significant cardiac, skeletal, and chromosomal anomalies. The most common associated anomalies in the gastroschisis patient are atresias or stenoses of the mid-gut which can be considered a part of the gastroschisis defect rather than distinct embryologic entities.

The gastroschisis defect is situated to the right of the umbilicus, containing edematous small and large intestine not covered by a membrane (Figure 1). The omphalocele is a covered, centrally-located defect giving rise to an eccentrically-positioned umbilical cord. Due to the exposed bowel, gastroschisis patients have a higher incidence of fluid and electrolyte losses, sepsis, and gastrointestinal dysfunction. Recent advances in surgical techniques and management have improved the survival rate in gastroschisis; however, survival rates with omphalocele remain unchanged due to serious associated anomalies.

**Figure 1. The gastroschisis defect is situated to the right of the umbilicus, containing edematous small and large intestine not covered by a membrane.**

### Clinical Material

Over a two-year period (January, 1977, to December, 1978), nine patients born with gastroschisis were managed at West Virginia University Medical Center, Morgantown, West Virginia. Details of their preoperative status and treatment, surgical procedures and postoperative management and complications follow.

Maternal age ranged from 15 to 33 years, averaging 20.6 years, with eight of nine patients being first-born children. Five patients were male and all were Caucasian. One patient was delivered by cesarean section. The birth weight of seven patients was less than 2.5 kilograms, and the gestational age was less than 38 weeks in six patients. All defects were right-sided lesions and contained variable segments of stomach and mid-gut.

Thirty-three per cent of the cases in this series had gastrointestinal anomalies. One patient had a jejunal stenosis and bilateral club feet, another had an ileal atresia, and the third a colon atresia with a jejunal stenosis. No other anomalies occurred.

All patients were managed preoperatively with nasogastric decompression and intravenous fluids. Each patient received Gentamicin and Ampicillin preoperatively and until 24 hours after final closure. Seven silastic silos were placed as the initial procedure and all defects were extended vertically. One primary fascial closure with a colostomy was performed in a patient with an associated colon atresia. A second primary closure with a side-to-side entero-enterostomy for an associated jejunal stenosis was performed elsewhere. Second-stage fascial closures were completed three to seven days — averaging 4.7 days — following silo construction.

Postoperatively, all patients received some form of intravenous nutrition. Seven were maintained on central venous alimentation for between 12 and 41 days. Most patients demonstrated some form of gastrointestinal dysfunction, remaining NPO for between eight and 50 days, averaging 22 days. They were slow to advance to full oral caloric intake for age, ranging 16 to 120 days from birth and averaging 48 days. Predigested formula, such as Portogen, was well-tolerated if increased at a slow rate.

There have been no deaths in the management of our gastroschisis patients. There have been no wound complications associated with the silo. Sixty-seven per cent of our patients demonstrated some form of gastrointestinal dysfunction, including two short gut syndromes, one malabsorption problem, and three with prolonged motility problems. One patient developed respiratory insufficiency requiring ventilatory support after primary fascial closure.

Two patients developed small bowel obstruction postoperatively. One required re-exploration and developed a superficial wound infection. One patient had meconium aspiration at birth and developed bilateral pneumothoraces during resuscitation. One case of septicemia and one case of jaundice were associated with central venous alimentation.

### Case Reports

B.C. is a 2500-gm., 37-week firstborn transported from Huntington, West Virginia. A two-centimeter, right-sided defect containing small bowel was present. The defect was enlarged and a silo constructed on admission. No other anomalies were found. Fascial closure was performed at five days. Oral fluids were begun on the eighth hospital day. The patient was discharged on a diet for age the seventeenth hospital day weighing 2.7 kg.

J. E. is a 1900-gm., 36-week firstborn transferred from Monongalia General Hospital. A three-centimeter, right-sided defect containing small and large bowel was present. A proximal jejunal stenosis and right colon atresia were noted to be present. A primary fascial closure with a colostomy and gastrostomy were initially performed. The patient developed respiratory insufficiency the first postoperative day requiring mechanical ventilatory support. Persistent partial proximal small bowel obstruction secondary to the jejunal stenosis necessitated a segmental jejunectomy the thirtieth hospital day. The patient was managed on central venous nutrition for 41 days and began oral feeds six days after the resection. The patient was discharged the forty-fourth hospital day on a diet for age weighing 2.5 kilograms.

### Management

When a patient is born with a gastroschisis, immediate transfer to a pediatric surgical intensive care unit should be arranged. Hypothermia and acidosis should be corrected and nasogastric suction should be initiated. A dry sterile dressing should be placed over the contents of the defect and wrapped around the abdomen. Wet dressings, even with Saran Wrap, will cause hypothermia. Transport should be completed as soon as possible.

*Preoperative Preparation.* On admission, a detailed history and physical examination is completed. Nasogastric suction and intravenous fluids are begun. Each patient is placed on intravenous Gentamicin (five mg/Kg/day) and Ampicillin (100 mg/kg/day) and is given a dose Vitamin K (one mgm). Immediate surgical correction is undertaken.

*Surgical Procedure.* Under oro-tracheal general anesthesia, the contents of the defect and the abdominal wall are prepped with warm Betadine and draped. The defect is enlarged in a cephalic and caudal direction to at least double the size of the defect. The umbilicus is excised and the umbilical vessels carefully ligated at a distance from the edge of the defect. Careful exploration for gastrointestinal anomalies is undertaken. If there are no anomalies, the silastic silo is constructed and secured to the abdominal wall with permanent 0 sutures (Figure 2). No attempt is made to create a water-tight

**Figure 2. A silastic silo is constructed and secured to the abdominal wall with permanent 0 sutures. A gastrostomy tube may be placed.**

suture line. A sterile dressing is placed over the silo.

If an atresia is found, exteriorization of the proximal bowel is required. A primary anastomosis in this edematous bowel is avoided if possible. Primary closure of the abdominal wall defect is recommended if an enterostomy is performed to eliminate contamination of the silo. If full oral alimentation is possible, the patient may be discharged and the enterostomy closure done electively. If malabsorption due to short bowel develops, the patient is maintained on intravenous alimentation and the enterostomy is closed when necessary.

*Postoperative Management.* In patients with a silo, sterile dressing changes are done and the contents gradually reduced daily (Figure 3). Reduction should be complete in three to five days and a secondary fascial closure completed (Figure 4). Patients are maintained on antibiotics until 24 hours after fascial closure. If the contents have not significantly reduced after five days, an undiagnosed intestinal stenosis or atresia should be highly suspected. If the bowel fails to reduce or if the baby deteriorates secondary to sepsis, he should be returned to the operating room. The silo should be removed, the bowel examined for anomalies and viability, and either a primary fascial or skin flap closure performed.

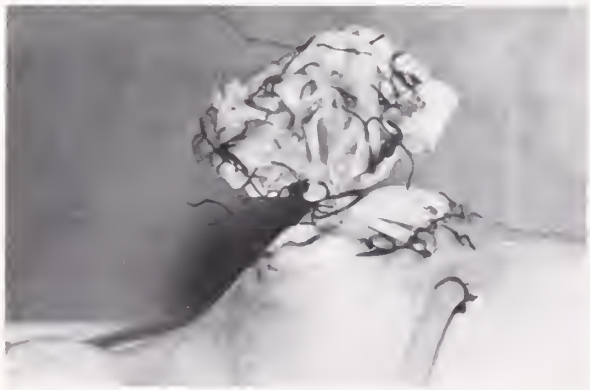

**Figure 3. The contents of the silo are gradually reduced daily.**

**Figure 4. Delayed fascial closure is completed in three to five days.**

Postoperatively, all patients will require intravenous nutrition. If a long period of nutritional support is anticipated, a central venous catheter is placed after the fascial closure has been completed. Oral alimentation is advanced slowly as tolerated with a pre-digested elemental formula. Intravenous nutritional support is maintained until a full oral diet is tolerated.

### Discussion

Gastroschisis is a treatable anomaly that ideally should have a minimal morbidity and no mortality. Our series, though still small, suggests several aspects that may reduce morbidity and improve survival in the management of gastroschisis.

All patients with gastroschisis should be initially transferred to a neonatal intensive care facility. It is clear that these patients may require: (1) mechanical ventilatory support, (2) multiple operations, and (3) long-term central venous alimentation for nutritional support to assure normal growth and development.

All patients undergoing a silo construction had their defects extended to at least twice the original size. This modification increased the ease and rapidity of reduction of the contents of the silo. The original small defect may obstruct return of the exteriorized bowel to the abdominal cavity and act as a potential site for volvulus and strangulation. Fascial closures were completed between three and seven days. This short period of time minimized potential wound complications and sepsis. Brown, Roty and Kilway reported a series of seven patients in 1978 using a similar technique with no mortality.[12] If the contents of the silo will not reduce by five days an undiagnosed obstruction should be suspected and the patient should be reexplored. This problem occurred in one patient and an ileal atresia was found.

Our experience with associated intestinal atresia suggests that primary fascial closure of the defect with enterostomy and delayed anastomosis is preferred if possible. Eliminating the silo in the presence of an enterostomy minimizes potential sepsis. Bowel anastomosis is more satisfactory if delayed until a later date. One case treated initially with a bypass later required a resection and anastomosis. Two cases with fascial closure and enterostomy had no wound complications. One of these patients is

home with an ileostomy. The other required enterostomy closure prior to discharge due to malabsorption of water and electrolytes.

These methods of management and modifications in surgical technique have resulted in no wound complications and no mortality. These results should add to the continuing improvement in the manaegment of gastroschisis.


### Summary

Gastroschisis is a newborn emergency which may require complex, long-term surgical management. Historically, primary closure, skin flaps and early silo techniques resulted in reduced but significant morbidity and mortality. New modification such as, (1) expansion of the defect to expedite reduction and (2) primary closure with enterostomy in cases with associated atresia along with (3) the availability of ventilatory support and central venous alimentation, have further improved results. Gastroschisis has few serious associated anomalies and should be a totally correctable anomaly with minimal morbidity and no mortality.


### References


1. Bernstein P: Gastroschisis: A rare teratological condition in the newborn. *Arch Pediatr* 57:505, 1940.

2. Watkins DE: Gastroschisis: *Va Med Mon* 70:42, 1943.

3. Moore TC, Stokes GE: Gastroschisis: Report of 2 cases treated by a modification of the Gross operation for omphalocele. *Surg* 33:112, 1953.

4. Gross RE: A new method for surgical treatment of large omphaloceles. *Surg* 24:277, 1948.

5. Schuster SR: A new method for staged repair of large omphaloceles. *Surg Gynecol Obstet* 125:837, 1967.

6. Hollabaugh RS, Boles ET: The management of gastroschisis. *J Pediatr Surg* 8:263, 1973.

7. Zwiren GT, Andrews HG: Progress in the management of gastroschisis. *Am Surg* 40:45, 1974.

8. Rubin SZ, Ein SH: Experience with 55 silo pouches. *J Pediatr Surg* 11:803, 1976.

9. Aaronson IA, Eckstein HB: The role of the silastic prosthesis in the management of gastroschisis. *Arch Surg* 112: 297, 1977.

10. Amoury RA, Ashcraft KW, Holder TM: Gastroschisis complicated by intestinal atresia. *Surg* 82:373, 1977.

11. Moore TC: Gastroschisis and omphalocele: Clinical differences. *Surg* 82:561, 1977.

12. Brown AL, Roty AR Jr, Kilway JB: Increased survival with new techniques in treatment of gastroschisis. *Am Surg* 44:417, 1978.


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# Hospital Mortality In 342 Hip Fractures

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*Hospital mortality in 342 hip fractures was studied by the authors. In this article, factors associated with increased hospital mortality — male sex, mental incompetence on admission, mental confusion developing in the hospital, cardiovascular disease and pulmonary disease — are analyzed. The authors conclude that surgical treatment and prophylactic anticoagulation were associated with decreased hospital mortality.*

DESPITE a decline in mortality rate over the past 30 years,[15, 17] hip fractures continue to dominate orthopedic surgery mortality conferences. In a community hospital, we analyzed significant prognostic and treatment factors in hospital deaths following hip fractures. While the hip fracture mortality rate is greater than the general population, even following hospital discharge,[14, 15] the factors affecting a patient in the hospital are more directly under a physician's control.

### Materials and Methods

Three hundred, forty-two hip fractures were admitted to the services of 12 orthopedic surgeons between 1972 and 1977 at Cabell-Huntington Hospital, Huntington, West Virginia, one of the two trauma hospitals in this community. Charts on these patients were analyzed retrospectively. Data were analyzed according to the Chi squared distribution or the Student's T distribution. Level of significance chosen was P less than 0.05.

### Results

The overall mortality rate was 10.0 per cent (34/342). Autopsies were obtained on 19 of these 34 patients. Primary causes of death were: cardiac failure (9); pulmonary embolism (4); renal failure (2); pulmonary edema (2); and myocardial infarction (2). The age of patients admitted was 74 ± 15 years, age of survivors, 73 ± 16 years, and age of the deceased, 82 ± 9 years.

The hospital stay among those not treated surgically was 15 ± 11 days for survivors and 6 ± 7 days for the deceased. In the surgical population, the hospital stay was 23 ± 13 days for survivors and 20 ± 18 days for the deceased.

### Prognostic Factors

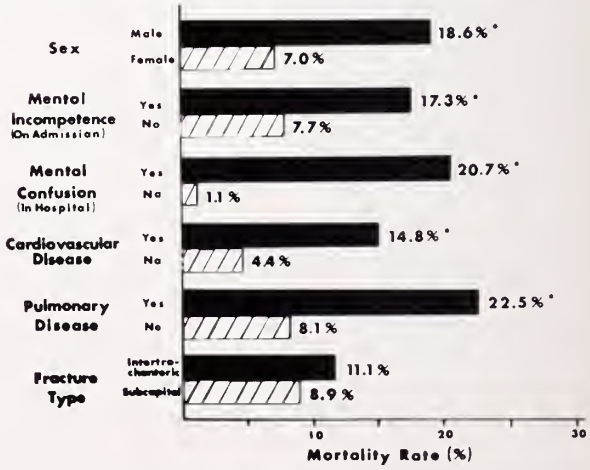
There were 86 males (25.1 per cent) and 256 females in the study. The mortality rate for the males was 18.6 per cent, compared to 7.0 per cent for the females (Figure 1).

One hundred, ten persons (32.2 per cent) were judged to have some degree of mental incompetence or confusion upon admission to the hospital. The mortality rate for those having various mental conditions was 17.3 per cent, compared to 7.7 per cent for those not having any pre-existing mental problem (Figure 1).

Twenty-five per cent of 232 patients with no prior history of mental incompetence developed mental confusion during their hospital stay. The mortality rate among those developing mental confusion was 20.7 per cent; whereas, among those who remained mentally clear throughout their hospital period, the mortality rate was 1.1 per cent (Figure 1).

One hundred, eighty-two (53.2 per cent) of the 342 patients had either a history or findings of cardiovascular disease or hypertension. The mortality rate of the group with cardiovascular disease was 14.8 per cent, compared to 4.4 per cent for that group of patients admitted without any cardiovascular disease (Figure 1).

Forty-five patients (13.2) per cent who were admitted had or developed significant pulmonary




*Significant difference (P less than 0.05).

**Figure 1. Hospital mortality in 342 hip fractures: prognostic factors.**

disease. The mortality rate of those people having pulmonary disease of all types was 22.2 per cent, while that of those persons not having any pulmonary problems was 8.1 per cent (Figure 1).

One hundred, fifty-seven of the 342 fractures were femoral neck fractures (45.9 per cent), and there were 185 intertrochanteric fractures. The mortality rate for femoral neck fractures was 11.1 per cent while that of the intertrochanteric fractures was 8.9 per cent.

Standard ASA anesthesia grading on surgical patients did not correlate with hospital mortality.[1]

Frequency analysis for the interrelationships among the factors studied demonstrated significant interrelationships between sex, pulmonary disease, mental condition, and cardiovascular disease. Interestingly enough, while the male population demonstrated a lower frequency of cardiovascular disease (42.5 per cent vs. 56.8 per cent), the mortality rates for male and female were reversed. The incidence of pulmonary disease among males and females (27.5 per cent vs. 8.2 per cent) correlated directly with the mortality rate difference.

### Treatment Factors

Two hundred, ninety-eight of the 342 fractures were treated surgically (87.1 per cent). The mortality rate in the surgical group was 7.4 per cent, whereas the mortality rate in the nonsurgical group was 27.3 per cent (Figure 2). Comparative frequency analysis of surgical and conservative treatments with prognostic factors revealed a positive correlation with mental problems. Although cardiovascular disease and pulmonary disease were both more frequent in the conservatively-treated population than the surgically-treated population, when tested for interrelationships, these were not found to be statistically significant. Whether surgery was done on the day of admission or delayed one or more days did not alter the mortality rate.

Five patients developed pneumonia while in the hospital. Three of these patients died.

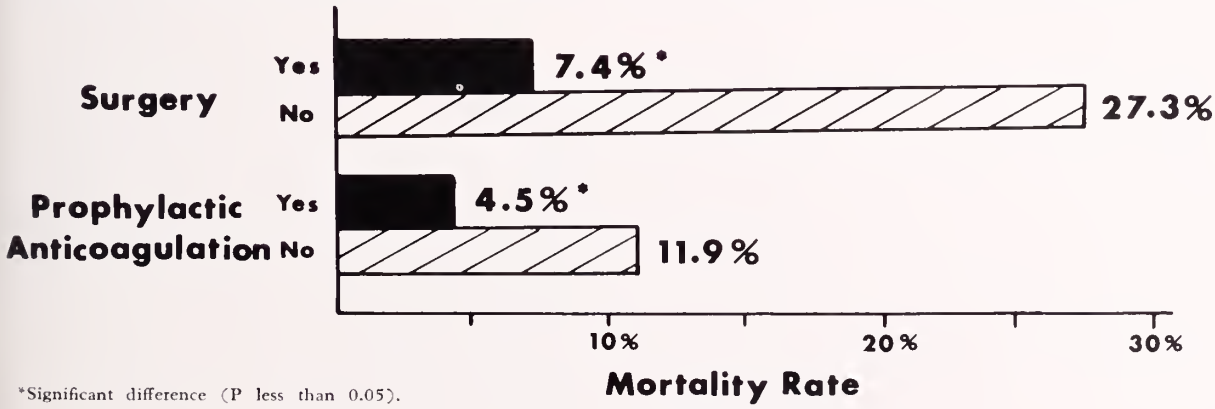
Prophylactic anticoagulants were used in 89 cases (26.0 per cent). The mortality rate among those patients having anticoagulants was 4.5 per cent, compared to 11.9 per cent for those patients who did not have anticoagulants (Figure 2). In the surgical group, four of 87 patients having prophylactic anticoagulants died (4.6 per cent), and 22 of 211 patients not having anticoagulants died (10.4 per cent). The lower mortality rate following prophylactic anticoagulation was significant for both the surgical group and the group as a whole. Comparative frequency analysis of prophylactic anticoagulation with prognostic and treatment factors showed no significant interrelationships other than with the surgical and conservative treatment groups.

### Discussion

The present study supports the general knowledge that age,[3, 14] sex,[1, 3, 14] cardiovascular disease,[1] pulmonary disease,[1] and mental confusion[14] still represent significant risk factors in the patient with a hip fracture.

Prophylactic anticoagulation is not uniformly used by orthopedic surgeons.[19] Death is the ultimate complication. Since prophylactic anticoagulation in this study is associated with a reduced mortality rate, it is recommended that all patients with hip fractures receive anticoagulants. In this community in 1970, 10 per cent of hip fracture patients were prophylactically anticoagulated,[18] as compared to 26 per cent currently.

The present study did not support the hypothesis that hip surgery should be done on an emergency basis;[7, 10, 12] nor did it support the hypothesis that delay is advantageous.[9, 11, 13] Similar results were reported by Barnes *et al.*[3]




*Significant difference (P less than 0.05).

**Figure 2. Hospital mortality in 342 hip fractors: treatment factors.**

### Ambulation and Mortality Rate

Miller's study[14] is quite striking in the 51 per cent of patients who did not achieve ambulatory status died within one year of injury. Ambulation is difficult to achieve with conservative treatment. The mortality rate following surgery in this and other studies is lower when surgical and nonsurgical treatments are compared. Although this undoubtedly represents a selection process, the risk of surgery[4, 5, 6, 8] should be weighed carefully against the risk of failure to achieve ambulation.[3, 14, 16]

Mental confusion in the elderly is often regarded lightly by the medical and paramedical staff. Humorous epithets such as "sundowners" or "nightfighters" are used. Mental confusion may be a symptom of blood sugar or electrolyte aberrations, renal failure, gastrointestinal disturbance, infection, drug overdose, delirium tremens, hypoxia, $CO_2$ narcosis, and anemia, to name a few. Senility is a diagnosis of exclusion. Mental confusion is more common and more grave than a high fever and should be appropriately evaluated. Nurse's notes and drug history should be checked. Physical examination, oral and intravenous intake, urinary output, complete blood count, electrolytes, blood sugar, serum calcium, blood gases, chest x-ray, and electrocardiogram should be done on the confused patient if he was previously clear mentally.

### References


1. Aldrete JA, Davis HS, Hingson RA: Anesthesia factors in the surgical management of hip fractures. *J Trauma* 7:818, 1967.

2. Arnold WD, Lyden JP, Minkoff J: Treatment of intracapsular fractures of the femoral neck with special reference to percutaneous Knowles pinning. *J Bone Joint Surg* 56A:254, 1974.

3. Barnes R, Brown JT, Garden RS, Nicoll EA: Subcapital fractures of the femur. *J Bone Joint Surg* 58B:2, 1976.

4. Clawson DK: Intertrochanteric fracture of the hip. *Am J Surg* 93:580, 1957.

5. Cleveland M, Bosworth DM, Thompson FR: Intertrochanteric fractures of the femur: A survey of treatment in traction and by internal fixation. *J Bone Joint Surg* 29:1049, 1947.

6. Evans EM: The treatment of trochanteric fractures of the femur. *J Bone Joint Surg* 31B:190, 1949.

7. Fitts WT, Lehn HB, Schor S, Roberts B: Life expectancy after fracture of the hip. *Surg Gynecol Obstet* 108:7, 1959.

8. Harmon PH: The fixation of fractures of the upper femur and hip with threaded, hexagon-headed, stainless-steel screws of fixed length. *J Bone Joint Surg* 27:128, 1945.

9. Kern IB: Fracture of the neck of the femur: A review of 308 cases treated at the Prince of Wales hospital from January 1960 to June 1961. *Med J Aust* 49:554, 1962.

10. Leventhal GS: Intertrochanteric fractures: Treatment by open reduction and nailing under direct vision. *Surg Clin North Am* 33:1559, 1953.

11. Lorhan PH, Shelby EA: Factors influencing mortality in hip fractures. *Am J Surg* 108:645, 1964.

12. Lowell JD: Fractures of the hip. *New Engl J Med* 274:1418, 1966.

13. McGoey PF, Evans J: Fractures of the hip: Immediate versus delayed treatment. *Canad Med Assoc J* 83:260, 1966.

14. Miller CW: Survival and ambulation following hip fracture. *J Bone Joint Surg* 60A:930, 1978.

15 Mulholland RC, Gunn DR: Sliding screw plate fixation of intertrochanteric fractures. *J Trauma* 12:581, 1972.

16. Sarmiento A: Avoidance of complications of internal fixation of intertrochanteric fractures. *Clin Orthop* 53:47, 1967.

17. Schwartz AD, Salamon PB: Treatment and mortality in intertrochanteric fractures: A graphic review. *Orthop Review* 5:47, 1976.

18. Scott TF: Review of one year's hip fracture experience in Huntington, West Virginia. *WVa Med J* 71:142, 1973.

19. Simon TL, Stengle JM: Antithrombotic practice in orthopaedic surgery. *Clin Orthop* 102:181, 1974.

# The Management Of Grief

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*Grief following death of a loved one, following surgical loss, or in an anticipatory form when the patient is battling a potentially lethal illness, is a universal phenomenon. It can, however, take a pathological course, and it is important for the physician to be able to differentiate between normal and abnormal grief reactions.*

*Features of typical and atypical grief reactions are reviewed, and practical issues in management of the bereaved are discussed.*

PROFESSIONALS and laymen alike would agree that there are few blows to the human spirit so severe as the loss of a close loved one. Traditional wisdom asserts that we can be crushed by grief and die of a broken heart, and that a jilted lover has been known to do things that are foolish or plainly dangerous to himself or others. The basis for these phenomena we term an attachment bond — that is, the attraction one individual has for another individual. The British psychiatrist, John Bowlby, has been most influential in studying attachment bonding in humans.[1] He sees the most intense bonds developing between parents and their offspring, and between adults of the opposite sex. Threats to the attachment bond arouse anxiety, hostility, and proximity-keeping behavior. Actual loss of the bond creates sorrow, grief, efforts to find the lost one and, in humans, the beginning of the homeostatic mechanism of mourning. It would appear, then, that grief and mourning are the price man pays for his capacity to fall in love and form families.

### Normal Grief and Mourning

Normal grief following death or a prolonged separation from a loved one is so stereotyped in its features and outcome that we would be tempted to label it an illness if we were not aware of its universality. Lindemann,[2] in 1944, was the first to study systematically the acute grief process when he studied relatives of people killed in the Coconut Grove night club fire and subsequently added to these from his psychiatric practice. However, they were not totally typical of "normal" or "uncomplicated" grief because they had consulted a psychiatrist.

A natural study of grief was undertaken by Marris,[3] who was able to interview 72 randomly-selected widows in East London whose names he had traced through published death notices of their husbands. From his findings we can sketch the typical reaction to bereavement over a close and loved relative (Table 1).

At first there is a period of "shock" or "numbness" which may last a few hours or up to two weeks. Thereafter, paroxysmal attacks of yearning and distress for the lost one with autonomic disturbance begin. These attacks appear in waves and are especially acute when the bereaved is reminded of the loved one. Between attacks the bereaved is depressed, apathetic, hopeless, and may even have transitory suicidal thoughts. Insomnia, anorexia, restlessness, irritability and hostility are often present. Paradoxically, he may be most angry at those closest to him, including family, physicians, and the clergy; furthermore, he can't explain why he is so angry.

The bereaved is preoccupied with thoughts of the deceased and death in general. The deceased is felt to be still present. There is a tendency to search actively for him and to idealize him by selectively remembering only the good times shared. The intensity of these features starts to abate after one to six weeks and is minimal by six months, although exacerbations and remissions of intense feelings are common. For at least several years, occasional brief periods of sadness and yearning may be precipitated by reminders of the loss. On the other hand, it is

**TABLE 1**
**Features of Normal Grief**

| *Features* | *Percentage of "Normal" Widows Showing Feature* |
|---|---|
| 1. Depression or Anxiety | 100 |
| 2. Apathy | 61 |
| 3. Insomnia | 79 |
| 4. Cultivation of idea of presence | 21 |
| 5. Sense of presence of deceased | 50 |
| 6. Execution of acts associated with deceased | 21 |
| 7. Attempts to escape reminders of deceased | 18 |
| 8. Difficulty in accepting loss | 23 |
| 9. Blames self | 11 |
| 10. Blames others | 15 |

unlikely that grieving ever is completed by parents who lose young children even though serious overt signs are absent. Typically, in an uncomplicated grief reaction, the features are not so severe as to cause consultation with a physician, missing more than two weeks' work, committing suicide, drinking excessively, or isolating oneself from friends and relatives.

Concomitant with the external manifestations of grief, an internal psychological process begins: this homeostatic process, which helps the bereaved cope with the loss of the loved one and adapt to a new reality that does not include the loved one, we call mourning.[4, 5] The work of mourning requires the bereaved to perceive the reality of the permanence of the loss; to acknowledge the significance of the loss: to deal with the sudden disruption of his normal daily activities with its attendant fears, worries, frustration, rage and pain; and to be able to invest his time effectively and his affections in new persons, activities, or ideals. He ultimately must replace his attachment and affection for the loved one with attachments to others who, though not exact substitutes, can permit mutually satisfying relationships. Usually, a fondness for the loved one remains. He is remembered not ideally but realistically, and the bereaved has been made a better person and strengthened by his former attachment.

### Abnormal Grief and Mourning

Parkes[6, 7, 8] studied 115 psychiatric outpatients who came for treatment of emotional illness which had presented within six months of the death of a parent, spouse, sibling, or child. He felt that most of them were suffering from complicated grief reactions and, in addition, some of the patients presented with classical psychiatric symptom pictures such as psychosomatic disorders, psychoneurotic disorders, depressions and manias, schizophrenia-like syndromes, and addictive disorders. The features which appeared to differ most from patterns of normal grief were prolonged and intensified grief, persisting self-blame and guilt over the death, and difficulty in accepting the reality and finality of the loss (Table 2). He further subdivided the abnormal grief responses into delayed grief, chronic grief, inhibited grief, and mixed reactions (Table 3).

*Delayed grief* occurs when a normal or chronic grief reaction takes place after a period of delay during which the normal expression of grief is absent. Sometimes the normal "numbness" is present during the period of delay but most commonly does not occur. In Parkes' study, 33 per cent of the patients showed delay of grief onset beyond the expected two weeks. There did not appear to be any particular etiological factors to account for the delay, although some of the patients showed excessive guilt, social isolation, and outbursts of hostility and elation.

*Chronic grief* was the most common abnormality in Parkes' series, being found in 70 per cent of the total. He defined chronicity as the presence of a sustained, accentuated grief response for greater than six months following death. The picture was most commonly seen in young women and adolescents, and it was characteristic of them to be overwhelmed by their yearning and despair. In addition to the exaggeration of the normal grief response, other symptoms occurred. Guilt over supposed transgressions against the deceased were common. Approximately 25 per cent of the patients showed identification phenomena; that is, they developed symptoms similar to the deceased's during the terminal stages of his illness.

Especially among the adolescents, aggressive, delinquent or promiscuous behavior was noted, and there was an increased incidence of suicide if it were the parent of the opposite sex who died. The inability to mourn the passing of the loved one properly appeared related to the psychological maturity of the bereaved, his past history of managing previous losses, and the

**TABLE 2**
**Features of Pathological Grief**

| *Features* | *Percentage of "Bereaved" Patients Showing Feature* |
|---|---|
| 1. Prolonged grief | 71 |
| 2. Intensified grief | 62 |
| 3. Persisting self-blame | 67 |
| 4. Persisting difficulty in accepting loss | 67 |
| 5. Delay of onset more than two weeks | 38 |
| 6. Symptoms of last illness of deceased | 24 |
| 7. Panic attacks/nightmares of the deceased | 29 |

**TABLE 3**
**A Classification of Grief Reactions**

1. Normal Grief Reaction
2. Pathological Grief Reactions
   a. Delayed grief
   b. Chronic grief
   c. Inhibited grief
   d. Mixed reactions

quality of the relationship. Perhaps paradoxically, the more conflicted, ambivalent, and overly-dependent the former relationship had been, the more difficult it was for the bereaved to accept its termination.

*Inhibited grief* is probably a variant of delayed grief, and few investigators feel that grief is ever totally inhibited without some psychological sequelae Parkes saw no cases of inhibited grief in his series probably because of selection methods and age of the patients. Syndromes most resembling inhibited grief appear in the extremes of the life cycle. Bowlby[9] found that before the age of six, children seldom show a grief reaction lasting more than several weeks. However. their deeper yearning for the lost parent may manifest itself in excessive clinging, irritability, jealousy, temper tantrums and, in some cases, antisocial reactions — especially if the death resulted in a major dislocation for the child with his being placed in a series of foster homes. Furthermore, Bowlby felt that some forms of depressive illness in later life could be traced to major losses in childhood.

Evidence also exists that many of the overt signs of grief are absent in the elderly, although an increase of somatic complaints is often seen. It could be that there is a general "disengagement" from loved ones and society after age 65 so that events such as the death of a spouse or child are less traumatic.

Parkes designated a category of abnormal grief and called it *mixed or nonspecific reactions.* These include psychosomatic, affective, neurotic, psychotic, and addictive syndromes which occur within six months of the death of a loved one. It is difficult to assess whether these are truly variants of an abnormal grief response or whether in this case death is one more psychosocial stressor equivalent to divorce, loss of job, bankruptcy, etc. Whatever the exact mechanism, it certainly is apparent that there is an increased incidence of all psychiatric disorders and visits to the family physician for a host of physical complaints in at least some mourners.

Hackett[10] has described six important stress signs for persons with complicated or pathological grief reactions:

(1) Prolonged grieving

(2) False euphoria

(3) Self-destructive impulses

(4) Over-reaction to another person's troubles

(5) Development of symptoms of the deceased

(6) Activation of acute grief symptoms at important anniversaries connected with the deceased.

#### Grief Reactions to Losses Other Than Death

Although grief reactions are most severe following the death of a loved one, they may manifest themselves following other losses. Grief may be seen following surgical procedures and in an anticipatory form when the patient is battling a potentially terminal illness. Kaltreider *et al.*[11] recently studied 28 premenopausal women who underwent hysterectomy. Approximately 30 per cent of them showed evidence of a chronic grief reaction with unpleasant emotions, depression. nightmares. avoidance of sexuality, and failure to make an adequate social adjustment. Women who did well postoperatively had no future wish for children and were committed to achievement outside the home.

In another study. Derogatis *et al.*[12] found that long-term survival in women with metastatic breast cancer was related to the psychological coping mechanisms they employed. Somewhat paradoxically, the women who were most symptomatic emotionally; i.e., who demonstrated more anxiety, alienation, hostility, depression. and guilt, actually tended to survive longer than those who had fewer signs of overt dysphoria. It would appear those who externalized their fear and grief did better than those who internalized it through the mechanisms of denial and repression.

#### Physician Management of Grief Reactions

The physician is in a unique position either to facilitate or inhibit the necessary, normal grief process.[13, 14] A rule of thumb in dealing with the bereaved is neither to treat the normal grief response as a psychiatric illness in need of drug or other therapy, nor to ignore the signs of abnormal grieving and fail to give care because the signs and symptoms are readily explainable. Allowing the bereaved to express feelings is essential, and any statements that inhibit grief should be avoided. For example, there is no place for clichés like "It's God's will," Everyone's time must come," "What's one child when you have two more," and "You must be strong and go on." An understanding of the grief process will allow the physician to avoid being defensive if anger towards him is expressed; to be able to support the grieving by sharing memories of the deceased; and to visit or write the bereaved during the period of mourning. At times, one may have to encourage gently or give permission for the bereaved to return to work or socializing.

Cases of sudden death or where there is violence or disfigurement require special care because of intensified guilt and inability to prepare for the death and because the physician may be less likely to have a pre-existing relationship with the deceased. The family should be offered the opportunity to view the body, even if it is mutilated, after having been warned of the disfigurement. Although hospital red tape may prohibit it, allowing the bereaved to do something for the body is sometimes welcomed and helpful, especially when a child has died. Patience is needed in dealing with prolonged numbness in a family. A comforting word or little act of kindness will be long remembered. The provision of technical information about the cause of an unexpected death may alleviate some of a family's guilt. Furthermore, attention to the family's needs at this time may prevent the rare instance where its grief is expressed later in a malpractice lawsuit against the physician.

Evidence of a pathological grief reaction, such as lack of appropriate grief, exaggerated and intense grief, or chronic longing and preoccupation with the deceased requires the offering of appropriate support and counseling. Unusually severe reactions or the appearance of classical psychiatric syndromes may require consultation with a psychiatric colleague.

**References**


1. Bowlby J: Disruption of affectional bonds and its effects on behavior. Chapter in: Thoday and Parkes (eds): *Genetic and Environmental Influences on Behavior*, Edinburgh, Oliver and Boyd, 1968.

2. Lindemann E: Symptomatology and management of acute grief. *Am J Psychiatry* 101:141-148, 1944.

3. Marris P: *Widows and their Families*, London, Routledge and Kegan Paul, 1958.

4. Pollock GM: Mourning and Adaptation. *Int J Psychoanalysis* 17:341-361, 1961.

5. Freud S: Mourning and Melancholia. *Collected Papers of Sigmund Freud* 19:243-258.

6. Parkes DM: Bereavement and mental illness. Part 1. A clinical study of the grief of bereaved psychiatric patients. *Brit J Med Psychol* 38:1-12, 1965

7. Parkes DM: Bereavement and mental illness. Part 2. A classification of bereavement reactions. *Brit J Med Psychol* 38:13-26, 1965.

8. Parkes DM: *Bereavement: Studies of grief in adult life*. New York, International Universities Press, 1972.

9. Bowlby J: Childhood mourning and its implications for psychiatry. *Am J Psychiatry* 118:481-498, 1961.

10. Hackett TP: Recognizing and treating abnormal grief. *Hosp Physician* 10:49-56, 1974.

11. Kaltreider NB, Wallace A, Horowitz MJ: A field study of the stress response syndrome: Young women after hysterectomy. *JAMA* 242:1499-1503, 1979.

12. Derogatis LR, Abeloff MD, Melisaratos N: Psychological coping mechanisms and survival time in metastatic breast cancer. *JAMA* 242:1504-1508, 1979.

13. Hollingsworth CE, Pasnau RO: *The Family in Mourning: A Guide for Health Professionals*, New York, Grune and Stratton, 1977.

14. Cassem NH: Treating the person confronting death. Chapter in: Nicholi AM (ed): *The Harvard Guide to Modern Psychiatry*, Cambridge, Harvard Press, 1978.

113th ANNUAL MEETING

of the

# *West Virginia State Medical Association*

*The Greenbrier*

AUGUST 20-23, 1980

# PLAN NOW TO ATTEND

# *A message from . . .*

# *The President*

## REFLECTIONS ON A YEAR

REMEMBER how long Summers used to be? They were endless, terminated wilfully, it seems, only by the nostalgic wish to see last year's friends and classmates so that the Summer's adventures might be recounted to eager and envious ears.

Einstein's concept of time as relative and something plastic becomes somehow comprehensible when remembrance of those syrup-slow days confronts awareness of these in old-time movie quickstep.

The year speeds on. So many things planned are yet undone. One blessed reward of Medicine is our very busyness. No time for boredom. No chafing at inactivity. No pacing the floor in search of useful tasks.

A multitude of satisfying options is ours, no matter where we turn. Regret we know only through those second choices left undone. A regret quite close to that of the diner with straining shirt buttons as he wipes his chin, suppresses a slight burp and eyes the still laden smorgasbord, part of which he, out of some necessity, passed over.

"The best enjoyment follows work" is a statement I read recently in an essay. How very true. I agree, at least, for adults. And how fortunate are physicians at the opportunities for enjoyment we are given through our work.

At a time of sociological advancement and socioeconomic wisdom which dictates that, as a matter of personal pride and union loyalty, a worker should perform at the absolute minimum level of productivity, should it be at all surprising to find the degree of job dissatisfaction and general unhappiness so evident within Labor?

The only spark of wisdom in the arrangement is self-serving for the Union structure. It is a truism that without an unhappy membership, there would be no need for a Union. The only way a Union survives is by stirring and agitating and making unhappy its own membership. The work ethic is thus well designed to accomplish that essential purpose. Little work, little enjoyment. What an unhappy bargain!

A good part of my enjoyment during the past year has been the opportunity, in this column, to use the first person, singular. Many of you know that, wearing another hat, I have been known to voice opinion editorially in these pages. But that writing is another style, more formal. There are constraints. One must be meticulous in phrasing certain statements. At times, pure opinion must be expressed. For this we fall back on the first person, plural, the editoral *we*, more or less to hide in a crowd, it seems to me. There is always the worry that maybe someone in that crowd doesn't really agree.

Not so, here. The only one I put out on the limb is myself. I will miss the comfort of the solitude out there in my own green arbor. I might even miss the sound of the woodsman's saw.

Another author will appear here next month. I have known and respected Walter Fix for many years. I am sure all of you will join me in supporting him during the coming year.

Stephen D. Ward, M. D., *President*

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

For the West Virginia State Medical Association and West Virginians, August caps an aggressive, action-packed and highly productive 12 months. Legislative and other accomplishments will assure short and long-range benefits of a public health and welfare nature, as well as for providers of service.

**VERY GOOD YEAR**

Now Dr. Stephen D. Ward of Wheeling, who has built perhaps unprecedented momentum into many facets of Association operations, will turn over the Association Presidency, on August 23, to Dr. L. Walter Fix of Martinsburg. The next 12 months will bring some shift in emphasis — every President has particular goals and objectives — but there clearly will be no slowdown in the day-by-day pace.

Doctor Ward had a number of thing he wanted to accomplish when he took his oath of office at the Greenbrier a year ago. First on his priority list was a re-shaping of the Association's legislative image to make it more responsive to the profession and the public alike, and development of a strongly positive legislative program.

With a complete rewrite of the State Medical Practice Act in one 60-day legislative session; an effective new immunity statute for peer review committee records and proceedings, and a new brain death act, the Association's legislative accomplishments exceeded even the fondest expectations.

Additional funding which was provided for development of new medical rehabilitation beds and services, including facilities at the community level, was another major plus, with accelerated potential for critically needed advances in patient care in coming years.

Doctor Ward also placed major emphasis on more involvement by physicians in the political process, and he has advocated in strong fashion — in every part of the state he has visited — increased membership of West Virginia physicians in the American Medical Association. He likewise has stressed these points in writing in many ways.

There has been progress on both of these fronts, but Doctor Ward has been quick to tell his colleagues that the record still is "unsatisfactory." It's clear that his voice will continue to be heard, as the next Chairman of the Association's governing Council, on the West Virginia Medical Political Action Committee (WESPAC) and AMA issues. At the national level, he continues to serve on the AMA's highly important Council on Legislation.

Doctor Ward's year has provided one unique set of circumstances. He has been Editor of *The West Virginia Medical Journal* while serving as President. That situation has offered some special opportunities for leadership and for communica-

**Stephen D. Ward, M. D., President**

tion with the membership. He has handled that resource in an effective and highly professional manner, with his monthly President's Page in *The Journal* setting the direction and tempo for much of the Association's activity.

Through editorial comment, in particular, Doctor Ward has directed new attention to critical public problems of the day, such as those faced by the Department of Welfare's Medical Services Program. The past 12 months have brought further progress in work with the Workmen's Compensation Fund. Medical education has continued to receive detailed, priority attention — particularly the Association's role as the AMA accrediting arm for continuing medical education programs at community hospitals.

Steps for thorough review of possible alternatives in Association sponsorship of malpractice insurance coverage for its members have moved along in steady fashion. So has preliminary planning toward possible construction by the Association of its own headquarters building.

In still another move with significant potential, the Council accepted Doctor Ward's recommendation for appointment of a long-range planning committee. The President's Page in the July issue of *The Journal* offered some thoughts on that group's initial efforts. Its first series of endorsements and recommendations will be published in early fall, after appropriate review by Council.

After August 23, Doctor Ward will have a bit of time to review his year, and to provide the usual support and assistance Association Presidents always have accorded their successors. But this year's record will be there for all to see. There will be no reason for Doctor Ward to look upon it with other than a feeling of general satisfaction — and one of gratitude for the help the Association membership offered in substantial measure in making it, indeed, a very good year.

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They have been "at it" for two decades. Their record of service to the people of West Virginia and to their profession is tops. They are a fiercely proud and dedicated group, most jealous of the heavy responsibility they bear — and tireless when the pressure is on.

**A FIERCE PRIDE AND DEDICATION**

"They" are those stalwart physicians and members of the West Virginia State Medical Association who have given unselfishly of their time down through the years through service on the Association's Committee on Medical Scholarships.

The current committee, chaired by John Mark Moore, M.D., of Wheeling, and with all of its nine members present, carried out on June 6-8 in Bridgeport its annual assignment of interviewing applicants for the Association's medical school scholarships.

There were 35 young men and women, who will enter first-year classes this month at West Virginia and Marshall University Schools of Medicine, in this year's field. The Association grants each year four scholarships with an annual and four-year value of $1,500 and $6,000, respectively, to state residents beginning work toward M.D. degrees at the West Virginia schools.

The money for the scholarships comes from a $12-allocation from each Medical Association member's state dues. No student applicant leaves an interview without clearly understanding this — and most know the money "comes from the doctors" without a need to be told.

All applicants are invited for interviews each year. This year, 33 of the 35 appeared. On Saturday, June 8, the Committee worked from 8 A.M. until 10 P.M. in talking to 28 of these young people for an average of 20 minutes each.

The interviews represent a challenge for Committee members and students alike. And they provide a refreshing new confidence in the future of this Society of ours. But then comes the really hard work—the selection of the four scholarship recipients from an overall group with universally outstanding qualifications. Financial need, of course, is the greatest single factor in the selection process.

Again judging from the record, the Committee has met its responsibility in most satisfactory fashion over the years. Scholarship recipients now providing patient care have established outstanding patterns of community leadership, as well as professional expertise and service.

Of those who have completed undergraduate and graduate training, about three-fourth have entered practice in West Virginia. That figure perhaps could have been even a bit higher had more residency training opportunities been available in the state in the program's early years.

Those who have entered practice outside West Virginia have shown a high degree of professionalism in repaying their grants under provisions of their scholarship agreements.

From 1958 through 1961, the Medical Association granted one four-year scholarship each. The figure went to two in 1962, and to four in

1974. The 1980 recipients raise the total to 56, and they are identified in a story in the news section of this issue of *The Journal.*

It's more than a bit significant that a Committee on Medical Scholarships member appointed this year was himself a scholarship recipient. He is William L. Mossburg, M.D., a Fairmont surgeon, and his Committee colleagues extended a warm "welcome back" to him at Bridgeport.

Other current members of this Committee are Drs. Marshall J. Carper and Kenneth G. MacDonald, Sr., both of Charleston; Thomas J. Holbrook, Huntington; Robert L. Chamberlain, Buckhannon; Robert D. Hess, Clarksburg; James T. Hughes, Ripley, and Clark K. Sleeth, Morgantown, who has effectively handled for many years the detailed mechanics of the interview process.

Every member of the Medical Association well might, in his own way, extend a figurative salute to these physicians, and to others who have gone before them in equally outstanding fashion.

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**TRUE ADVOCACY**

We frequently are more than a little amused by the hackneyed words, phrases and the like that have become such a big part of the English language, All-American style.

To amount to anything, your efforts must have "thrust." Then there is the "bottom line." And standing tall among these and many others are the "consumer advocate" and the "special interest."

The consumer advocate usually is pictured as that stalwart guy—or gal—storming about on a white charger, beating the special interest into the dust. But is that always an accurate concept? We, in fact, have seen some consumer advocate groups that espouse more special interests than their "adversaries" possibly could assemble combined.

In the popular vein, if that's proper terminology, medicine often is pictured as a cornerstone of the special interest forces. Again, however, one needs to step back a bit and take a look at some history.

Active concern for quality is today the fundamental reason for organized Medicine's existence, and it always has been. Concern for quality has made Medicine a crusader for proper licensure for physicians; a leader in education, and a pacesetter in research.

Directly or indirectly, whatever Medicine does is intended to be for the public good. Early on, Medicine thus emerged as a consumer advocate—calling for a board of health in each state; a sewer system in each town; proper labeling of packages and bottles containing poisons, and special institutions rather than jails for the mentally ill.

Medicine's leaders of yesterday had to fight for many such advances taken for granted today. It was the American Medical Association's House of Delegates that adopted, in 1876, recommendations for purifying water-supply systems. That predated by a century the now controversial lifeline utility rate proposals.

It was Medicine that effectively recommended creation of the Food and Drug Administration; community-level mental health services; vitaminized milk and fruit juices; proper regulation of barbituates; safer cars and toys, and fluoridation of public water supplies.

What does all this say about Medicine? It offers loud and clear evidence that the profession cares *about* people as well as *for* them. In other words, it establishes that the "special interest" called Medicine ranks, in history and today, as one of the strongest "consumer advocate" components society ever has seen.

Significantly, the AMA's 1980 master plan contains six major missions totaling 46 major programs, which in turn offer more than 400 project-level activities. And the "bottom line" for all of this calls for promotion of the science and art of medicine — *and the betterment of public health.*

## *Our Readers Speak*

### Medicaid Editorial 'Objective'

I read the "Medicaid Problems" Editorial in your June, 1980, issue and must compliment you for your very objective and reality-based review of the situation in West Virginia. As an emergency physician, I recognize quite clearly the abuse encouraged by some third-party providers because of the way in which their regulations read. As a physician who has practiced in other states, I have seen the Emergency Department become the only available health resource for victims of the Medicaid system.

When elected officials consider Medicaid they paint the physician and hospital as the root of all evil. Although abuse clearly does exist, your article identifies the reality of consumer abuse being at least as significant. Although I do not expect any elected official to go out of his way to help us solve this problem, I wish to offer you my help in any way it may be of benefit. Thank you.

Jack R. Page, M.D., Chief
Department of Emergency Medicine
Charleston Area Medical Center

# GENERAL NEWS

## Plans Complete For 113th Annual Meeting Of Association

Plans were completed in July for the 113th Annual Meeting of the State Medical Association to be held August 20-23 at the Greenbrier in White Sulphur Springs.

Annual Meeting activities will get under way with a 2 P. M. meeting of the Association's Executive Committee on Tuesday, August 19; the usual preconvention meeting of the Council at 9:30 A.M. on Wednesday, and the opening session of the House of Delegates at 3 P. M. on Wednesday.

Dr. Robert B. Hunter of Sedro Woolley, Washington, who was installed as President of the American Medical Association during the AMA House's Annual Meeting in Chicago last month, will address the first House session.

Dr. William R. Barclay of Chicago, Editor of the Journal of the American Medical Association (JAMA), will deliver the keynote Thomas L. Harris Address during opening exercises on Thursday beginning at 9 A. M. "Scientific Journalism: The Backbone of Professionalism," will be the title of the presentation.

The annual address was established with a bequest in the will of the late Dr. Thomas L. Harris, Parkersburg surgeon who served as President of the Association in 1945.

#### Sections, Affiliated Societies

Some 12 Association sections and affiliated societies will hold breakfast and other meetings during the convention.

The Annual Meeting will continue through Saturday, August 23, when Dr. L. Walter Fix of Martinsburg, a pathologist, will be installed as Association President during the second and final session of the House of Delegates. Doctor Fix will succeed Dr. Stephen D. Ward, Wheeling psychiatrist.

Doctor Ward will deliver his address as the retiring Association President prior to the installation of Doctor Fix.

Dr. Robert D. Hess of Clarksburg, Chairman, will preside at the pre-convention meeting of the Council Wednesday morning, and Doctor Ward will preside at the first House session in Chesapeake Hall that afternoon.

Presentations of AMA Education and Research Foundation grants to West Virginia University and Marshall University Schools of Medicine also will be made during the first House session.

#### President's Reception

The President's Reception for Honor Guests will be held from 6:30 to 7:30 P. M. on Wednesday on the Old White Patio.

All three of this year's general sessions will be held in the theater, with the first to follow the 9 A. M. opening exercises on Thursday, August 21. The sessions on Friday and Saturday will be held at 9:30 A. M. and 9:45 A. M., respectively.

Several of the guest speakers have accepted invitations to present talks at meetings of the sections and affiliated societies of the Association.

**L. Walter Fix, M. D.**

## Convention Timetable

The first general scientific session will follow 9 A.M. opening exercises on Thursday, August 21. The Friday session will begin at 9:30 A.M., and the session on Saturday, at 9:45 A.M.

The first session of the House of Delegates will be on Wednesday afternoon, August 20, beginning at 3:00. The second session will be on Saturday afternoon beginning at 2:30.

The scientific exhibits will be located in Eisenhower Hall, adjacent to the theater. Physicians, members of the Auxiliary and their guests are urged to visit the exhibits, which will be open from 8:30 A. M. to the close of the morning sessions.

### Formal Opening Exercises

Doctor Ward will call the Annual Meeting to order at the 9 A. M. session on Thursday, with Dr. Joe N. Jarrett of Oak Hill to give the invocation. Doctor Ward will make welcoming remarks, and Dr. Martin D. Reiter of Wheeling, Chairman of the Program Committee, and the other members of his committee will be introduced. The first general session, with Dr. William A. Welton of Morgantown serving as moderator, will be held following the address by Doctor Barclay.

John A. Kenney, Jr., M. D., of Washington, D. C., will speak in the place of Harry M. Robinson, Jr., M. D., of Baltimore, as announced previously for the first session, who will be unable to attend.

Doctor Kenney, Professor and Chairman of Dermatology, Howard University College of Medicine, will present a paper on "Recent Advances in Dermatologic Therapy."

Certified in 1954, Doctor Kenney has been a member of the faculty at Howard since 1961. He is Vice President of the Dermatology Foundation, a member of the AMA Residency Review Committee for Dermatology, a Past President of the National Medical Association, and a Past President of the Washington, D.C., Dermatological Society.

Doctor Kenney is a member of the editorial boards of Skin and Allergy News; Cutis; and Journal of Sexually Transmitted Diseases.

A native of Alabama, he was graduated from Bates College in Lewiston, Maine, and received his M. D. degree in 1945 from Howard. He interned at Cleveland City Hospital, and completed postgraduate work at the University of Pennsylvania Graduate School of Medicine and the Department of Dermatology, University of Michigan Hospital.

John A. Kenney, Jr., M. D.

The other first-session speakers and their topics will be Joseph W. Burnett, M. D., Professor and Chairman, Division of Dermatology, University of Maryland School of Medicine, "Diagnostic Dermatologic Methods;" and Donald S. Robinson, M. D., Chairman, Department of Pharmacology, Marshall University School of Medicine, "Food- and Drug-Induced Diseases."

### Thursday Afternoon

A luncheon honoring Past Presidents of the State Medical Association will be held at 12:30 P. M. Thursday in the Tyler Room, with Doctor Hess scheduled to preside. The Association's Resolutions Committee, with Dr. Richard E. Flood of Weirton presiding, will meet at 2 P. M. Thursday in the Directors' Room.

### Friday Breakfast Meetings

All but one (to be noted) of the Friday morning breakfast meetings will begin at 7:30. The meetings, speakers (where scheduled) and their topics, and meeting rooms follow:

West Virginia Academy of Ophthalmology and Otolaryngology, James L. Bryant, M. D., Clarksburg, presiding, Washington Room;

Section on Internal Medicine, Harold Selinger, M. D., Charleston, presiding; "Development and Evaluation of New Vaccines," Maurice A. Mufson, M. D., Professor and Chairman, Department of Medicine, Marshall University School of Medicine, Lee Room;

## Luncheon For Past Presidents

A luncheon honoring Past Presidents of the West Virginia State Medical Association will be held at the Greenbrier on Thursday, August 21, during the 113 Annual Meeting.

Dr. Robert D. Hess of Clarksburg, Immediate Past President, will preside, and invitations have been extended to all the Association's Past Presidents.

## House of Delegates To Meet Twice During Meeting

The first session of the House of Delegates during the Annual Meeting at the Greenbrier will be convened at 3:00 P.M. on Wednesday, August 20. The second and final session of the House of Delegates will be held at 2:30 P.M. on Saturday, August 23.

Section on Dermatology, William A. Welton, M. D., Professor and Chairman of Dermatology, WVU Medical Center, Morgantown, presiding; presentation of case histories by individual members, including biopsies and clinical photographs; Doctor Welton, moderator; special guests John A. Kenney, Jr., M. D., and Joseph W. Burnett, M. D., Jackson Room;

Section on Surgery, Robert J. Reed III, M. D., Wheeling, presiding; "The Modern Peripheral Vascular Laboratory," Ronald A. Savrin, M. D., Assistant Professor of Surgery, WVU School of Medicine, Morgantown, Buchanan Room, and:

Section on Urology (8 A. M.), Stanley J. Kandzari, M. D., Morgantown, presiding; "Renal Trauma," John A. Belis, M. D., Assistant Professor of Urology, WVU School of Medicine, Morgantown, and "Male Infertility," Tara C. Sharma, M. D., Clinical Assistant Professor of Urology, Marshall University School of Medicine, Directors' Room.

### Second General Session

Dr. Mildred Mitchell-Bateman of Huntington will be the moderator at the second general session beginning at 9:30 A. M. on Friday. The speakers and their topics will be:

"The Primary Physician's Role in Care of the Chronically Mentally Ill" — Rogers J. Smith, M. D., Portland, Oregon, Chairman, AMA Council on Scientific Affairs; "The Chronic Mental Patient — Resources Necessary for Optimal Care" — Patrick R. Staunton, M. D., Chairman, Division of Psychiatry, Lutheran General Hospital, Park Ridge, Illinois, and "Learning Disabilities Associated with Medical Problems" — William B. Svoboda, M. D., Associate Professor, Pediatrics and Neurology, WVU School of Medicine, Morgantown.

### Friday Afternoon Schedule

The Association's Publication Committee, with Doctor Ward, Chairman, presiding, will meet at noon on Friday in the Buchanan Room.

Dr. David B. Gray of Charleston, Chairman, will preside at a meeting of the Association's Cancer Committee at 12:15 P. M. Friday in the Washington Room.

The Board of Trustees of the West Virginia Medical Institute, Inc., with Dr. Harry S. Weeks, Jr., of Wheeling presiding, will meet at 12:30 P. M. Friday in the Directors' Room.

Also meeting Friday afternoon will be the following sections and affiliated societies of the Association:

West Virginia Chapter, American College of Emergency Physicians, Walter H. Moran, Jr., M. D., Morgantown, presiding; "Drug Poisonings and Overdoses, and Drug Information Centers," Donald S. Robinson, M. D., and "Dermatologic Lesions Seen by Emergency Room Physicians," Joseph W. Burnett, M. D. (business meeting to follow speakers), 1:00, Pierce Room;

Section on Orthopedic Surgery, Richard H. Sibley, M. D., Charleston, presiding; "Noiles Total Knee Replacements as a Salvage Procedure for Failed Arthroplasties or Severe Deformities," Charles W. Newman, M. D., Lincoln, Nebraska, 2:00, Tyler Room;

## Nominating Committee To Meet On Friday, August 22

The State Medical Association's Committee on Nominations will hold a 5 P.M. meeting on Friday, August 22, in the Directors' Room of the Greenbrier.

The Committee will make nominations to the House of Delegates for President Elect, Vice President and Treasurer, and for Delegate and Alternate Delegate to the American Medical Association.

Association By-Laws also provide that nominations may be made from the floor for these offices, to be filled by the House in balloting at its final session on Saturday, August 23, the final day of the Association's 113th Annual Meeting.

Dr. John J. Mahood of Bluefield will serve as Chairman of the Committee on Nominations, with other members to include: Drs. William L. Mossburg, Fairmont; Leo H. T. Bernstein, Martinsburg; Vernon E. Duckwall, Elkins; Harry Shannon, Parkersburg; Winfield C. John, Huntington; Carl R. Adkins, Fayetteville, and Arthur E. Levy, Williamson.

In addition, one of the Kanawha Medical Society's two Councilors will serve on the Committee under provisions of the By-Laws. The representative will be Dr. Carl J. Roncaglione of Charleston.

## The 1980 Program Committee

Chairman of the Program Committee for the 113th Annual Meeting of the West Virginia State Medical Association is Dr. M. D. Reiter of Wheeling. Other Committee members are Drs. L. Walter Fix of Martinsburg, David K. Heydinger of Marshall University's School of Medicine in Huntington, Joseph B. Reed of Buckhannon, Stanley Roy Shane of the West Virginia University School of Medicine faculty, and John F. I. Zeedick of South Charleston.

West Virginia District Branch, American Psychiatric Association, Charles C. Weise, M. D., Charleston, presiding; "Impaired Physician Role of the Psychiatrist," Rogers J. Smith, M. D., and "Future of the State Hospital System," Patrick R. Staunton, M. D., 2:00, Lee Room;

West Virginia Chapter, American Academy of Pediatrics, Herbert H. Pomerance, M. D., Charleston, presiding; "Common Dermatological Problems in Children," John A. Kenney, Jr., M. D., 2:00, Fillmore Room, and

West Virginia Chapter, American Society of Internal Medicine, Alfred K. Pfister, Charleston, presiding, 4:00, Jackson Room.

The Association's Committee on Nominations, with Dr. John J. Mahood of Bluefield presiding, will meet at 5 P. M. in the Directors' Room.

### Saturday Morning Schedule

The West Virginia Radiological Society, with Dr. Orlando F. Gabriele of Morgantown presiding, will meet at 8 A. M. Saturday in the Lee Room.

Doctor Flood will preside at the third general session beginning at 9:45 A. M. Saturday. The speakers will be Clinton S. McGill, M. D., Portland, Oregon, a member of the AMA's Speakers' Bureau, "AMA Membership and Other Services," and James E. Drake, Washington, D.C., Director, Department of Congressional Relations, AMA Washington Office, "The AMA in Washington."

## No Registration Fee for Members

Members of the West Virginia State Medical Association will not be assessed a registration fee in connection with the 113th Annual Meeting at the Greenbrier in White Sulphur Springs, August 20-23.

Interns, residents and medical students also will be registered without charge.

There will be a registration fee of $50 for out-of-state physicians attending the meeting.

### Saturday Afternoon

The West Virginia State Society of Anesthesiologists, with Dr. John F. I. Zeedick of Charleston presiding, will meet at noon on Saturday in the Directors' Room. Donald S. Robinson, M. D., of Huntington will speak on "Drugs to be Wary of in the Perioperative Patient."

### Second House of Delegates Session

Doctor Ward again will be the presiding officer at the second and final House of Delegates session in Chesapeake Hall at 2:30 P. M. on Saturday. Along with his Presidential Address and the installation of Doctor Fix, the agenda will include election of other Association officers and consideration of several business items.

### Medical School Alumni Events

Cocktail parties will be held by the West Virginia University School of Medicine's Alumni Association Thursday evening, and by the University of Virginia Medical School Foundation and the West Virginia Chapter, Medical College of Virginia Alumni Association, Friday evening.

Dr. John E. Jones will be in charge of the WVU festivities in the West Virginia Room Thursday at 6:30 P. M. Dr. William C Morgan will serve in the same role for the University of Virginia affair at 6 P. M. Friday in the West Virginia Room. Dr. Joseph A. Smith will be in charge of the Medical College of Virginia event at 6:30 P. M. Friday on the Old White Patio.

The Auxiliary to the State Medical Association will sponsor a "Monte Carlo Night" Friday beginning at 9:30 in Chesapeake Hall. The Cabell County Auxiliary will be the host auxiliary, with Mrs. Charles E. Turner of Huntington serving as Chairman. All physicians, their spouses and others registered for the State Medical Association convention are invited. Tickets may be purchased at the Auxiliary registration desk.

### Saturday Evening Reception

New and continuing officers of the State Medical Association will be honored at a cocktail party and reception from 6:30 to 7:30 P. M. Saturday on the Colonial Hall Terrace. All members of the Association and Auxiliary and their families, representatives of scientific exhibitors and convention guests are cordially invited.

## Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb. Wright, Ph. D., Coordinator, Continuing Education. Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal).

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

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| Sept. 5-6 | Morgantown | Urology Reunion Days |
| Sept. 25-26 | Morgantown | 6th Annual Hal Wanger Family Practice Conference |
| Oct. 2 | Morgantown | Annual Pediatric Teaching Day |
| Oct. 3-4 | Morgantown | W. Va. Chapter, American College of Surgeons |
| Oct. 11-13 | Charleston | Biomechanics in the Practice of Orthopedic Surgery |
| Oct. 17 | Morgantown | Nutrition and Metabolism Seminar |

### Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

*Cabin Creek* (2nd Wed., 8-10 A. M.)

*Welch, Stevens Clinic Hospital* (3rd Wed., 11 A. M.-1 P. M.)

August 20

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| Office Dermatology | Robert B. Point, M. D. |

*Buckhannon, Upshur-Buckhannon Middle School* (3rd Thurs., 7-9 P. M.)

September 18

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|---|---|
| Infectious Diseases | Patrick Robinson, M. D. |

October 16

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|---|---|
| Medico-Legal Aspects of Health Delivery | Richard D. Lindsay, M. D., J. D. |

*Oak Hill, White Oak Country Club* (4th Tues., 7-9 P.M.)

*Whitesville, Raleigh-Boone Medical Center* (4th Wed., 11 A. M.-1 P. M.)

September 24

| | |
|---|---|
| Dermatology: Recognizing Skin Diseases | Robert B. Point, M. D. |

*Williamson, Appalachian Power Company Auditorium* (1st Tuesday, 6-8 P. M.)

## Visiting Mayo Clinic Speakers, Subjects Announced

Sessions on biliary tract diseases and breast cancer will make up the program for the one-day "Dr. William E. (Bill) Irons Symposium" to be held September 8 in Huntington at the Marshall University Student Center.

The speakers, all from the Mayo Clinic, and their topics for the morning session on biliary tract diseases will include "X-Ray Diagnosis in Gall Bladder Disease"—Robert L. MacCarty, M. D., Assistant Professor of Diagnostic Radiology; "Medical Management of Gallstones"—Johnson L. Thistle, M. D., Associate Professor of Medicine; "Radiological Aspects of Diseases of Biliary Ducts"—Doctor MacCarty;

"Medical Management of Biliary Ductal Stones"—Doctor Thistle, and "Surgical Treatment of Biliary Disease"—Oliver H. Beahrs, M. D., Professor of Surgery.

James A. Coil, Jr., M. D., Associate Professor of Surgery, MU School of Medicine, will moderate the morning session.

The Mayor Clinic speakers and topics for the afternoon session will be "Surgical Management

of Breast Cancer"—Doctor Beahrs; "Oncologic Management of Breast Cancer"—Richard G. Hahn, M. D., Associate Professor of Medical Oncology, and "Post-Mastectomy Breast Reconstruction"—George B. Irons, M. D., Assistant Professor of Surgery and a nephew of the late Doctor Irons, Huntington surgeon in whose memory the symposium is being held.

George J. Hill II, M. D., MU Professor and Chairman of Surgery, who is conference Chairman, will moderate the afternoon session.

Sponsored by the MU School of Medicine and St. Mary's Hospital in Huntington, the program has been approved for six hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association and LCCME, and for six hours of prescribed credit by the American Academy of Family Physicians.

The registration fee, which includes lunch, will be $30 for physicians, $10 for residents and nonphysicians, and $7.50 for medical students.

A program for spouses has been planned.

# *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*General Ophthalmology*, by Daniel Vaughan. M. D.; and Taylor Asbury, M. D. 410 pages. Price $15. Lange Medical Publications, Los Altos, California 94022. 1980.

*Current Pediatric Diagnosis and Treatment, 6th Edition*, by C. Henry Kempe. M. D.; Henry K. Silver, M. D.; and Donough O'Brien, M. D. 1122 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1980.

*Review of Medical Microbiology, 14 Edition*, by Ernest Jawetz, Ph.D., M. D.; Joseph L. Melnick, Ph.D.; and Edward A. Adelberg, Ph.D. 592 pages. Price $14. Lange Medical Publications, Los Altos, California 94022. 1980.

*The Chemistry of Human Behavior*, by Herbert L. Meltzer, Ph.D. 261 pages. Price $17.95. Nelson-Hall Publishers, 325 W. Jackson Boulevard, Chicago, Illinois 60606. 1979.

The conference will open at 8:45 A. M. with remarks from Robert W. Coon, M. D., MU Vice President for Health Sciences, and Albert C. Esposito, M. D., MU Clinical Professor of Surgery.

Additional information and registration materials may be obtained by writing: Dr. Charles W. Jones, CME Office, School of Medicine, Marshall University, Huntington 25701. Telephone (304) 696-4822.

## Medical Association Announces Scholarship Winners

Recipients of four 1980 scholarships who will enter medical schools at West Virginia University and Marshall University this fall have been announced by the West Virginia State Medical Association.

Dr. John Mark Moore of Wheeling, Chairman of the Association's Committee on Medical Scholarships, announced these winners, each of whom will receive $1,500 for each of his or her four years of undergraduate medical training:

Maudie Lee Adkins of Wayne, in Wayne County, and Marsha Lee Bailey of Dunbar, both

Maudie Lee Adkins

Marsha Lee Bailey

Carol Lynn Johnson

Roger Alan Ray

of whom will enter the first-year medical school class at Marshall this month; and Carol Lynn Johnson of Charleston and Roger Alan Ray of Huntington, who will begin their studies at West Virginia University.

Miss Adkins, daughter of the late Earl M. Adkins and Mrs. Dora Letha Adkins, received a B. S. degree in medical technology from Marshall in 1977, and has been employed as a medical technologist at St. Mary's Hospital in Huntington.

Miss Bailey is a 1980 graduate of WVU with a B.A. degree in chemistry. She is the daughter of Mr. and Mrs. Harold K. Bailey of Dunbar.

Miss Johnson, daughter of Mrs. Pauline Johnson of Charleston, also received a B.A. degree in chemistry from WVU this year.

Ray has completed more than three years of undergraduate work at the University of Virginia in Charlottesville, and will receive a degree in chemistry after additional hours of credit he will receive in medical school. He is the son of Mr. and Mrs. Paul A. Ray of Huntington.

The new awards bring to 56 the number granted by the Medical Association to deserving young West Virginia men and women since it began its scholarship program in 1958. It awarded one scholarship annually until going to two in 1962.

It then increased the number in 1974 to the current four with the objective of further encouraging young physicians to establish practice in the state.

## Physician Participation Asked In Hypertension Study

Dr. R. John C. Pearson of Morgantown is looking for physicians who would like to participate in a study of their hypertensive patients to see how well they are being controlled.

Doctor Pearson, Professor and Chairman of the Department of Community Medicine at West Virginia University Medical Center, said there would be a protocol that would be followed in order to achieve uniform findings.

"Whether the results would be published is open to discussion, but the main purpose would be to help individual physicians conduct a self-assessment of their therapeutic successes," he added.

Interested physicians may call Doctor Pearson at (304) 293-2502.

## Auxiliary Completes Program For 56th Annual Meeting

Mrs. John F. (Mary Ellen) Vaughan of Vancouver, Washington, will be among honor guests when the Auxiliary to the West Virginia State Medical Association holds its 56th Annual Meeting at the Greenbrier in White Sulphur Springs August 20-23.

The meeting again will be held concurrently with the Annual Meeting of the State Medical

Mrs. John F. Vaughan

Mrs. Raymond M. Yow

Association. Mrs. Vaughan was installed in July as the new President of the American Medical Association Auxiliary.

Also addressing the Auxiliary will be Mrs. Raymond M. Yow of Salisbury, Maryland, President of the Southern Medical Association Auxiliary.

More than 200 wives of physicians are expected to attend the Auxiliary's business sessions, over which Mrs. D. Sheffer Clark of Huntington, the Auxiliary's President, will preside.

### Preconvention Meetings

An invitation has been extended to all Auxiliary members to attend the first session of the State Medical Association's House of Delegates on Wednesday, August 20, at 3 P. M. Dr. Robert B. Hunter, AMA President, will be the principal speaker.

Mrs. Clark then will preside at a 4 P. M. preconvention Auxiliary Board meeting in the Fillmore-Van Buren Rooms.

### Opening Convention Exercises

Members of the Auxiliary also have been invited to attend formal opening ceremonies of the State Medical Association's 113th Annual Meeting at 9 A. M. on Thursday, August 21, in the theater. Dr. William R. Barclay of Chicago, Editor of the Journal of the American Medical

**Mrs. D. Sheffer Clark**

Association (JAMA), will deliver the eighth annual Thomas L. Harris Address.

Following the opening exercises, the Auxiliary members will go to the Fillmore-Van Buren Rooms for the formal opening of their convention, with Mrs. Clark in charge.

#### First General Session

The keynote address by Mrs. Vaughan will highlight the initial session at 9:45 A. M. Dr. Stephen D. Ward of Wheeling, President of the State Medical Association, will be recognized for brief remarks.

A member of the Board of Directors of the AMA Auxiliary since 1973, Mrs. Vaughan has served the national organization as Secretary, Executive Committee member, Western Regional Vice President, Chairman of the Family Health Committee, and Program Development Committee member. In addition, she was Western Regional Chairman of the Health Education and Children and Youth committees, and a member of the 1971 and 1974 Nominating committees.

On the state level, Mrs. Vaughan has held the offices of President, First Vice President, Regional Vice President, Recording and Corresponding Secretary, and Chairman of the Mental Health Committee.

A native of Carrington, North Dakota, Mrs. Vaughan received her B. S. degree in education from the University of North Dakota, with majors in English and music. Before her marriage, she was a secondary English and music teacher.

In addition to her auxiliary activities, Mrs. Vaughan has served on her county's Social Services Administration Board and Executive Committee, chaired the administration's Drug Sub-Committee, and served seven years on the Governor's Council on Drugs.

Doctor Vaughan is a family practitioner in Vancouver.

#### Other Opening-Session Items

Other opening-session items will include the introduction of the convention Chairman, Mrs. M. Bruce Martin of Huntington; reports from officers and committee chairmen; recommendations from the preconvention board meeting, election of the 1981 Nominating Committee, and introduction of component Auxiliary Presidents by the Regional Directors.

#### Bridge, Golf, Past Presidents' Breakfast

A bridge tournament beginning at 2 P. M. will be held on Thursday in the Trellis Lobby. The Kanawha County Auxiliary will serve as host auxiliary, with Mrs. J. L. Mangus of Charleston as Chairman.

Golf may be played either Thursday or Friday afternoon. Monongalia County, with Mrs. George A. Curry of Morgantown as Chairman, will be host auxiliary.

At 8 A. M. on Friday, August 22, the Past Presidents' breakfast will be held in the Virginia Room, with Mrs. Joseph T. Mallamo of Fairmont presiding.

#### Second General Session

The Second General Session at 9:45 A. M. on Friday in the Fillmore-Van Buren Rooms again will have Mrs. Clark presiding, with a highlight to be the address by Mrs. Yow.

Other activities will include presentation of AMA-ERF Awards by Mrs. Robert S. Robbins and Mrs. John W. Kennard, both of Wheeling, State AMA-ERF Co-Chairmen, to Dr. John E. Jones, Dean, West Virginia University School of Medicine, and Dr. Robert W. Coon, Dean, Marshall University School of Medicine.

Mrs. Vaughan will install Mrs. Gary G. Gilbert of Huntington as President, and other new officers, and Mrs. Gilbert will deliver her inaugural address.

#### Friday Social Functions

The Kanawha County Auxiliary, with Mrs. Alfredo C. Velasquez and Mrs. Thomas J. Janicki as Co-Chairmen, will be host auxiliary for tennis on Friday afternoon.

As noted, golf may be played either Thursday or Friday afternoon.

"Monte Carlo Night," beginning at 9:30, will be held in Chesapeake Hall. The Cabell County Auxiliary, with Mrs. Charles E. Turner of Huntington as Chairman, will be the host auxiliary. Tickets may be purchased at the Auxiliary registration desk.

#### Postconvention Board Meeting

Mrs. Gilbert will preside at the postconvention conference and board meeting at 10 A. M. on Saturday, August 23, in the Fillmore-Van Buren Rooms.

#### Saturday Afternoon Agenda

Auxiliary members are invited to attend the second and final session of the State Medical Association's House of Delegates on Saturday at 2:30 P. M., at which time Dr. L. Walter Fix of Martinsburg will be installed as the Association's President, and other Association officers will be elected.

#### Other Convention Matters

Those Auxiliary members who plan to participate in bridge, golf and tennis are urged to sign up in advance at the registration desk.

## Constitution, By-Laws Changes Up For House Deliberation

Several important constitution and by-laws changes will be up for initial consideration or final action during annual sessions of the State Medical Association's House of Delegates at the Greenbrier August 20 and 23.

To be introduced, and to lie over for a year, will be proposed constitutional and by-laws amendments to open the Association membership to doctors of osteopathy, and to students at the school of osteopathy in West Virginia.

The House will have up for final action:

A by-laws amendment to increase the annual state membership dues from $150 to $250 for active members, effective with the 1981 calendar and dues year.

Constitution and by-laws revisions which would increase the size of the Association Council by providing for a second councilor for any district with 200 or more members; and an additional councilor for each 100 members above the 200.

A by-laws amendment to require at least two nominees for each office in annual elections of Vice President, Treasurer, American Medical Association Delegate and AMA Alternate, with the amendment to be in effect for 1981 balloting.

A clean-up by-laws amendment to bring some language in line with the new State Medical Practice Act as it now provides for a West Virginia Board of Medicine, as contrasted to the old Medical Licensing Board of West Virginia.

The proposed revisions relative to the Council increase also would be effective with elections of councilors by the House in 1981, and could increase from the current 15 to 20 the number of representatives from the 14 councilor districts. The district embracing Kanawha, Boone, Clay and Putnam counties now has two councilors.

## MU Schedules Geriatric CME Program In October

"Geriatric Medicine: Today and Tomorrow" will be the theme for a two-day continuing medical education conference this fall hosted by the Marshall University School of Medicine.

Scheduled for Thursday and Friday, October 16-17, the sessions will be held in the Student Center on the MU campus in Huntington, and will carry 12 hours of Category 1 credit from the American Medical Association and LCCME.

Although designed primarily for physicians, the conference is open to all interested health care professionals and would be valuable to those working in geriatric areas, according to a Medical School spokesman.

The panel of 16 speakers includes a number of nationally-recognized leaders in the field of geriatric medicine who represent some of the nation's most respected medical centers, the spokesman said.

Launching the two full days of intensive seminar sessions will be Colin Currie, Member of the Royal College of Physicians, who is senior lecturer for the University Department of Geriatric Medicine at City Hospital, Edinburg, Scotland. Doctor Currie, currently Visiting Professor in the Duke Watts Family Practice Program at Duke University Medical Center, will discuss "The Uniqueness of Managing the Elderly Patient."

#### Develops Home Care Programs

Having an extensive background in management of the elderly patient on both an inpatient

and outpatient basis, Doctor Currie also has been involved in developing and assessing home care programs for the aged in Scotland, and organized an in-service training program in geriatric medicine for junior hospital doctors in the Edinburgh area.

The full list of speakers and topics follows:

"Normal Physiology of Aging"—Morton D. Bogdonoff, M. D., Professor of Medicine, Cornell University Medical College; "Nutritional Consideration in the Elderly"—Richard Bozian, M. D., Professor of Medicine, University of Cincinnati College of Medicine; "Management of Maturity Onset Diabetes Mellitus in the Older Patient"—Thomas G. Skillman, M. D., Kurts Professor of Endocrinology, Ohio State University College of Medicine; "Thyroid Disease in the Elderly: Diagnosis and Management"—Bruce S. Chertow, M. D., Professor of Medicine, MU;

**Infections In Elderly**

"Infections and Their Usual Presentation in the Elderly"—Maurice A. Mufson, M. D., Professor and Chairman of Medicine, MU; "Proper Use of Antibiotics in the Elderly"—Joseph E. Johnson III, Professor and Chairman of Medicine, Wake Forest University Bowman Gray School of Medicine; "Management of Common Skin Disorders in the Elderly"—Charles Yarbrough, M. D., Clinical Assistant Professor of Medicine, MU; "Management of Arthritis in the Elderly"—John C. Huntwork, M. D., Clinical Associate Professor of Medicine, MU; "Problems of Hypertension in the Aged"—Donald G. Vidt, M. D., Clinical Section Head, Hypertension/Nephrology Department, Cleveland Clinic Foundation; "Problems of Drug Therapy in the Elderly"—Joseph R. Bianchine, M. D., Ph. D., Professor of Pharmacology/Medicine and Pharmacology Department Chairman, Ohio State University College of Medicine; "Altered Pharmacokinetics and Aging"—Donald E. Melnick, M. D., Assistant Professor of Pharmacology, MU; "The Agitated Elderly Patient"—Robert P. Granacher, M. D., Associate Clinical Professor of Psychiatry, University of Kentucky College of Medicine;

**Rehabilitation and Elderly**

"Rehabilitation and the Elderly"—Theodore M. Cole, M. D., Professor and Chairman of Physical Medicine/Rehabilitation, University of Michigan Medical School; "Drug Interactions in the Elderly"—Donald S. Robinson, M. D., Professor and Chairman of Pharmacology, MU; and "Urinary Infections in the Elderly"—William C. Graham III, M. D., Assistant Professor of Medicine, MU.

Doctors Robinson and Cole also will conduct sessions on "Use and Abuse of Antidepressants" and "Sexual Problems in the Elderly," respectively.

The program format includes question-and-answer sessions following the seminars. In addition, the speakers will be available for informal discussions during lunch.

A reception and banquet have been planned for Thursday evening. A variety of activities for the spouses will be available, including a tour of a glass factory and a luncheon visit to the Huntington Galleries.

**Physicians' Fee $60**

There will be a $60 registration fee, which includes lunch both days, for physicians. The fee for other health care professionals will be $40. Additional information on the conference or registration materials may be obtained by writing Dr. C. W. Jones, Continuing Medical Education Director, School of Medicine, Marshall University, Huntington 25701. Telephone (304) 696-4822.

## Jail Physician Sought In Cabell County

A physician to serve the needs of the inmates of the Cabell County Jail is being sought by the Cabell County Commission.

The physician would be expected to make rounds at the jail twice a week and be on call for emergencies. If the applicant is in a group pratcice, it would be helpful if his partners would be willing to be on call in an emergency if the regular jail physician were unavaliable, the Commission said.

Information on salary, and arrangements for interviews may be obtained by calling Mrs. Jody Smirl, Administrative Assistant, at (304) 525-8071.

## Three-Mile Run Added To Meeting Program

Joggers and other running enthusiasts attending the State Medical Association's 113th Annual Meeting August 20-23 at the Greenbrier will have a new opportunity to keep their training programs on schedule.

Added to the convention's extra-curricular activities this year will be a three-mile run on Saturday, August 23, at 7:15 A.M. Physicians and auxiliary members will be able to participate and still have time to attend general scientific.

board, business and other meetings scheduled for later in the morning.

The run, with Dr. Harvey D. Reisenweber of Martinsburg as the Chairman, will begin and end at the hotel's north entrance (that providing the normal exit to the golf and tennis club).

It will offer some uphill as well as on-the-level challenges as it winds behind some of the resort's cottages, the golf club and the tennis courts.

## Sports Events Again Planned For Annual Meeting

Golf, tennis and skeet competition again are scheduled during the State Medical Association's 113th Annual Meeting August 20-23 at the Greenbrier in White Sulphur Springs.

Dr. Marcel G. Lambrechts of Charleston is the Medical Golf Tournament's defending champion, having been the winner for the past two years; while Drs. Jesus T. Ho of Moundsville and R. C. Jereza of Beckley will have an opportunity to defend tennis honors limited to doubles competition.

Dr. Gary G. Gilbert of Huntington won the 1979 skeet tournament.

The Medical Association's Auxiliary likewise will offer golf and tennis doubles competition, with Mrs. William E. (Maxine) Gilmore of Vienna the defending golf champion, and Mrs. Whaja Park of Charleston and Mrs. Sonya Wong of Baltimore, Maryland, the 1979 tennis winners.

**The Smith triplets, now at home with their parents, Mr. and Mrs. Jason Smith of Coalfax (Marion County), pay a return visit to West Virginia University Hospital where they were born in March 11 weeks prematurely and hospitalized in the Newborn Intensive Care Unit. The now-thriving triplets (from left), Jessica Marie, Jaye Lee and Jamie Lynn, are held by (from left) their mother, Terri, Barbara Nightingale, NICU nurse, and Dr. Martha D. Mullett.**

# *Medical Meetings*

Aug. 7-8—2nd Annual Sports Med. Clinic (MCV), Richmond, Va.

Aug. 10-14—Sixth Western Hemisphere Nutrition Conference, Los Angeles.

**Aug. 20-23—113th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.**

Sept. 3-6—Am. Assn. of Obstetricians & Gynecologists, Hot Springs, Va.

Sept. 4-5 — Diagnostic Ultrasound in Obstet.-Gynecol., Johns Hopkins, Baltimore.

Sept. 8—William E. Irons, M. D., Surgical Symposium, Huntington.

Sept. 8-10—Am. Neurological Assn., Boston.

Sept. 11-12—40th Annual Congress on Occupational Health of the AMA, Salt Lake City.

Sept. 21-25—Am. College of Radiology, New Orleans.

Sept. 27-29—Drug in Medical Practice (AMA theme meeting), Kansas City, Mo.

Sept. 28-Oct. 3—Am. Society of Plastic & Reconstructive Surgeons, New Orleans.

Oct. 6-9—AAFP, New Orleans.

Oct. 9-11—Am. Cancer Society, Los Angeles.

Oct. 10-12—Pediatric Approach to Common Neurological Problems (Johns Hopkins), Ocean City, Md.

Oct. 16-17—Geriatric Conference (MU School of Med.), Huntington.

Oct. 17-19—AMA Regional Meeting, Huron, Ohio.

Oct. 19-24—ACS Clinical Congress, Atlanta.

Oct. 24-26—AMA Regional Meeting, Philadelphia.

Oct. 26-30—Am. College of Chest Physicians, Boston.

Oct. 29-Nov. 1—Fourth National Conference on the Impaired Physician (AMA, Med. & Chirurgical Faculty of Md.), Baltimore.

Nov. 2-7—Am. Academy of Ophthalmol., Chicago.

Nov. 9-13—International Congress for Interferon Research, Washington, D. C.

Nov. 12-15—Am. Heart Assn., Miami.

Nov. 13-15—A National Forum on Comprehensive Cancer Rehabilitation and its Vocational Implications (Va. Dept. of Rehabilitative Services, MCV), Williamsburg, Va.

Nov. 14-16—AMA Regional Meeting, New York City.

Nov. 16-19—Southern Med. Assn., San Antonio, Texas.

**1981**

**Jan. 23-25—14th Mid-Winter Clinical Conference, Charleston.**

# CONVENTION PROGRAM

## 113th ANNUAL MEETING

**of the**

## *West Virginia State Medical Association*

**THE GREENBRIER, WHITE SULPHUR SPRINGS**

**August 20-23, 1980**

### WEDNESDAY MORNING

**August 20**

**(Eastern Daylight Time)**

9:00-5:00—Registration, Registration Lobby.

9:30—Pre-Convention Meeting of the Council. Robert D. Hess, M.D., *Presiding* (Lee Room, with Luncheon in Fillmore-Van Buren Rooms).

### WEDNESDAY AFTERNOON

3:00—First Session of the House of Delegates. Stephen D. Ward, M.D., *Presiding* (Chesapeake Hall).

Invocation—William E. Gilmore, M.D.

Address: Robert B. Hunter, M.D., President, American Medical Association.

Presentation of AMA-ERF Grants to the West Virginia University and Marshall University Schools of Medicine.

Business Meeting.

### WEDNESDAY EVENING

6:30-7:30—President's Reception for Honor Guests (Old White Patio).

### THURSDAY MORNING

**August 21**

8:30-5:00—Registration, Registration Lobby.

**Opening Exercise**

**(Theater)**

9:00—Call to Order—Stephen D. Ward, M.D., President, West Virginia State Medical Association.

Invocation—Joe N. Jarrett, M.D.

Address of Welcome—Stephen D. Ward, M.D.

Introduction of Martin D. Reiter, M.D., 1980 Program Committee Chairman, and other Members of his Committee.

"The Thomas L. Harris Address"

William R. Barclay, M.D., Chicago, Editor, *Journal of the American Medical Association.*

Subject: "Scientific Journalism: The Backbone of Professionalism."

**First General Session**

**9:45-12:30**

*Moderator*: William A. Welton, M.D.

9:45—John A. Kenney, Jr., M. D., Professor and Chairman of Dermatology, Howard University College of Medicine, Washington, D. C. Subject: "Recent Advances in Dermatologic Therapy."

10:30—Joseph W. Burnett, M.D., Professor and Chairman, Division of Dermatology, University of Maryland School of Medicine. Subject: "Diagnostic Dermatologic Methods."

11:15—Coffee Break to Visit Exhibits.

11:30—Donald S. Robinson, M.D., Chairman, Department of Pharmacology, Marshall University School of Medicine, Huntington. Subject: "Food- and Drug-Induced Diseases."

12:30—Recess for Lunch.

### THURSDAY AFTERNOON

12:30—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. Robert D. Hess, M.D., *Presiding* (Tyler Room).

2:00—Resolutions Committee. Richard E. Flood, M.D., *Presiding* (Directors' Room).

## THURSDAY EVENING

6:30—Cocktail Party. West Virginia University Alumni Association. John E. Jones, M.D., *In Charge* (West Virginia Room).

## FRIDAY MORNING

### August 22

8:30-5:00—Registration, Registration Lobby.

### Breakfast Meetings

7:30—West Virginia Academy of Ophthalmology and Otolaryngology. James L. Bryant, *M.D., Presiding* (Washington Room).

7:30—Section on Internal Medicine. Harold Selinger, M.D., *Presiding* (Lee Room).

Guest Speaker: Maurice A. Mufson, M.D., Professor and Chairman, Department of Medicine, Marshall University School of Medicine. Subject: "Development and Evaluation of New Vaccines."

7:30—Section on Dermatology. William A. Welton, M.D., *Presiding* (Jackson Room).

Moderator: Doctor Welton, Professor and Chairman of Dermatology, West Virginia University Medical Center, Morgantown.

*Special Guests*: John A. Kenney, Jr., M.D., and Joseph W. Burnett, M.D.

Presentation of Case Histories by Individual Members, Including Biopsies and Clinical Photographs.

7:30—Section on Surgery. Robert J. Reed III, M.D., *Presiding* (Buchanan Room).

Guest Speaker: Ronald A. Savrin, M.D., Assistant Professor of Surgery, WVU School of Medicine. Subject: "The Modern Peripheral Vascular Laboratory."

8:00—Section on Urology. Stanley J. Kandzari, M.D., *Presiding* (Directors' Room).

Guest Speakers: John A. Belis, M.D., Assistant Professor of Urology, WVU School of Medicine, Morgantown. Subject: "Renal Trauma." Tara C. Sharma, M.D., Clinical Assistant Professor of Urology, Marshall University School of Medicine, Huntington. Subject: "Male Infertility."

### Second General Session (Theater) 9:30-12 Noon

*Moderator*: Mildred Mitchell-Bateman, M.D.

9:30—Rogers J. Smith, M.D., Portland, Oregon, Chairman, American Medical Association Council on Scientific Affairs. Subject: "The Primary Physician's Role in Care of the Chronically Mentally Ill."

10:15—Patrick R. Staunton, M.D., Chairman, Division of Psychiatry, Lutheran General Hospital, Park Ridge, Illinois. Subject: "The Chronic Mental Patient — Resources Necessary for Optimal Care."

11:00—Coffee Break to Visit Exhibits.

11:15—William B. Svoboda, M.D., Associate Professor, Pediatrics and Neurology, West Virginia University School of Medicine, Morgantown. Subject: "Learning Disabilities Associated with Medical Problems."

12 Noon—Recess for Lunch.

## FRIDAY AFTERNOON

12:00—Publication Committee. Stephen D. Ward, M.D., *Presiding* (Buchanan Room).

12:15—Cancer Committee. David B. Gray, M.D., *Presiding* (Washington Room).

12:30—West Virginia Medical Institute, Inc., Board of Trustees. Harry S. Weeks, Jr., M.D., *Presiding* (Directors' Room).

1:00—West Virginia Chapter, American College of Emergency Physicians. Walter H. Moran, Jr., M.D., *Presiding* (Pierce Room).

Guest Speakers: Donald S. Robinson, M.D. Subject: "Drug Poisonings and Overdoses, and Drug Information Centers."

Joseph W. Burnett, M.D. Subject: "Dermatologic Lesions Seen by Emergency Room Physicians."

Business Meeting to Follow Speakers.

2:00—Section on Orthopedic Surgery. Richard H. Sibley, M.D., *Presiding* (Tyler Room).

Guest Speaker: Charles W. Newman, M.D., Lincoln, Nebraska. Subject: "Noiles Total Knee Replacements As a Salvage Procedure for Failed Arthroplasties or Severe Deformities."

2:00—West Virginia District Branch, American Psychiatric Association. Charles C. Weise, M.D., *Presiding* (Lee Room).

Guest Speakers: Rogers J. Smith, M.D., and Patrick R. Staunton. M.D. Subjects: "Impaired Physician Role of the Psychiatrist," and "Future of the State Hospital System."

2:00—West Virginia Chapter, American Academy of Pediatrics. Herbert H. Pomerance, M.D., *Presiding* (Fillmore Room).

Guest Speaker: John A. Kenney, Jr., M.D. Subject: "Common Dermatological Problems in Children."

4:00—West Virginia Chapter, American Society of Internal Medicine. Alfred K. Pfister, M.D., *Presiding* (Jackson Room).

5:00—Committee on Nominations. John J. Mahood, M.D., *Presiding* (Directors' Room).

## FRIDAY EVENING

6:00—Cocktail Party. The University of Virginia Medical School Foundation. William C Morgan, M.D., *in charge* (West Virginia Room).

6:30—Cocktail Party. West Virginia Chapter, Medical College of Virginia Alumni Association, Joseph A. Smith, M.D., *in charge* (Old White Patio).

9:30—Auxiliary "Monte Carlo Night," Cabell County, Host Auxiliary. Mrs. Charles E. Turner, *Chairman* (Chesapeake Hall).

## SATURDAY MORNING

### August 23

8:00—West Virginia Radiological Society. Orlando F. Gabriele, M.D., *Presiding* (Lee Room).

Business Meeting.

9:00-2:00—Registration, Registration Lobby.

### Third General Session

### (Theater)

### 9:45-12:00

*Moderator*: Richard E. Flood, M.D.

9:45—Clinton S. McGill, M.D., Portland, Oregon, Member, American Medical Association Speakers' Bureau. Subject: "AMA Membership and Other Services."

10:30—Coffee Break to Visit Exhibits.

11:00—James E. Drake, Washington, D.C., Director, Department of Congressional Relations, AMA Washington Office. Subject: "The AMA in Washington."

12 Noon—Recess for Lunch.

## SATURDAY AFTERNOON

12:00—West Virginia State Society of Anesthesiologists. John F. I. Zeedick, M.D., *Presiding* (Directors' Room).

Guest Speaker: Donald S. Robinson, M.D. Subject: "Drugs to be Wary of in the Perioperative Patient."

2:30—Second and Final Session of the House of Delegates. Stephen D. Ward, M.D., *Presiding* (Chesapeake Hall).

Invocation—Joseph T. Skaggs, M.D.

Presidential Address: Stephen D. Ward, M.D., President, West Virginia State Medical Association.

Presentation of New Officers of Auxiliary to the West Virginia State Medical Association.

Presentation of Honor Guests.

Business Meeting.

Election of Officers.

Installation of L. Walter Fix, M.D., Martinsburg, as President of the West Virginia State Medical Association.

## SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring Officers of the West Virginia State Medical Association (Colonial Hall Terrace).

# A WORD OF THANKS

**The 1980 Program Committee, and the officers and members of the West Virginia State Medical Association, wish to acknowledge with sincere thanks grants received from the following Firms to help support the Scientific Program for this year's 113th Annual Meeting.**

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(The firms listed above are those which had allocated funds to the Scientific Program as this issue of *The Journal* went to press. Additional contributors will be listed in the Official Program to be distributed at the Greenbrier.)

# 1980 PROGRAM COMMITTEE

M. D. Reiter, M. D.
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Chairman

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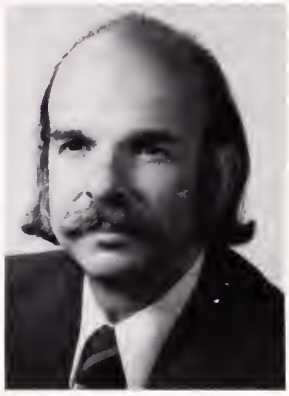

Stanley Roy Shane, M. D.
Morgantown

L. Walter Fix, M. D.
Martinsburg

Joseph B. Reed, M. D.
Buckhannon

John F. I. Zeedick, M. D.
South Charleston

# DELEGATES AND ALTERNATES

**BOONE** (2)—Delegates, Harold H. Howell and A. E. Glover, Madison.

**BROOKE** (2)—Delegates, W. T. Booher, Jr., Wellsburg; and Ralph McGraw, Follansbee. Alternates, Rogelio L. Velarde and Leticia Peralta-Velarde, Follansbee.

**CABELL** (13)—Delegates, Jack Leckie, K. V. Raman and Winfield C. John, Huntington; W. W. Mills and H. S. Mullens, Kenova; Albert C. Esposito, Robert W. Lowe, D. Sheffer Clark, M. Bruce Martin, Harry Karl Tweel, Maurice A. Mufson, William M. Jennings III and Tara Sharma, Huntington.

**CENTRAL WEST VIRGINIA** (4)—Delegates, R. Paul Bennett, Webster Springs; Clemente Diaz, Richwood; and John A. Mathias and Joseph B. Reed, Buckhannon.

**EASTERN PANHANDLE** (5)—Delegates, Leo H. T. Bernstein, William D. Strauch, Harvey D. Reisenweber, Francisco D. Sabado, Jr., and Jean P. Lucas, Martinsburg.

**FAYETTE** (3)—Delegates, Carl R. Adkins and Lewis A. Cook, Fayetteville; and Joe N. Jarrett, Oak Hill. Alternates, Chuan H. Lee, Oak Hill; A. M. Mirza and Afif S. Habash, Montgomery.

**GREENBRIER VALLEY** (4)—Delegates, Robert K. Scott II, Anthony Dougherty and James Pfeiff, Ronceverte; and Harvey A. Martin, White Sulphur Springs. Alternates, Lee B. Todd, Quinwood; Jose B. Caringal, Ronceverte; Edward A. Ricketts, Jr., White Sulphur Springs; and Romeo R. Ednacot, Ronceverte.

**HANCOCK** (4)—Ray S. Greco, George S. Kosar, George Naymick and Carlos L. Vasquez, Weirton.

**HARRISON** (6)—Delegates, Aristotle Rabanal, Salem; L. Dale Simmons, Clarksburg; William N. Walker, Jr., and Gaspar Z. Barcinas, Bridgeport; Catalino B. Mendoza and Carlos A. Naranjo, Clarksburg. Alternates, Louis C. Palmer, Bridgeport; John A. Bellotte and James Genin, Clarksburg; Julian D. Gasataya, Lumberport; Jaime E. Lazaro, Clarksburg; and Frederick A. Spencer, Jr., Salem.

**JEFFERSON** (2)—Delegates, L. Mildred Williams, Charles Town; and S. K. G. Menon, Ranson. Alternate, J. L. Van Metre, Charles Town.

**KANAWHA** (22)—Delegates, W. Alva Deardorff, South Charleston; Robert L. Ghiz, Carl B. Hall and Sherman E. Hatfield, Charleston; George W. Hogshead, Nitro; Edward Jackson, St. Albans; Kenneth G. MacDonald, Sr., Jimmy Lee Mangus and John B. Markey, Charleston; Carl J. Roncaglione, South Charleston; Joseph A. Smith, Dunbar; Pat A. Tuckwiller, Jean P. Cavender and John T. Chambers, Charleston; William D. Crigger, South Charleston; Theodore P. Mantz, Charleston; John V. Merrifield, Dunbar; Richard C. Rashid, South Charleston; and George A. Shawkey, John F. I. Zeedick, James W. Lane and Thomas J. Janicki, Charleston. Alternates, Prakash C. Bangani, Robert C. Bock and James P. Boland, Charleston; Donald E. Cunningham, St. Albans; Donald E. Farmer, George V. Hamrick and Echols A. Hansbarger, Jr., Charleston; Ruben W. Holland, Jr., and Ralph J. Holloway, South Charleston; J. Dennis Kugel, Tony C. Majestro, Eric P. Mantz, Ralph H. Nestmann, Robert B. Point, Warren Point, William C. Revercomb, Paul R. Santrock, Richard H. Sibley, Joseph T. Skaggs and Ralph S. Smith, Jr., Charleston; George E. Toma, South Charleston; and Charles C. Weise, Charleston.

**LOGAN** (3)—Delegates, Herbert D. Stern and Abelard A. Pelaez, Logan; and Thomas P. Long, Man. Alternates, Harry D. Fortner, Logan; Enrico V. Rallos, Gilbert; and Mark S. Spurlock, Logan.

**MARION** (5)—Delegates, Joseph T. Mallamo, Stanard L. Swihart, Charles E. Haislip, William L. Mossburg and John C. Turner, Fairmont. Alternates, Chi Meen Lee. G. David Leveaux, Joseph D. Romino, I. B. Taskin and Ann K. Clark, Fairmont.

**MARSHALL** (3)—Delegates, Kenneth J. Allen and Ignacio Luna, Jr., Glen Dale; and Jesus T. Ho, Moundsville. Alternates, E. Y. Baysal and Erol Bastug, Glen Dale; and Mohammad F. Anwar, Wheeling.

**MASON** (3)—Delegates, Aarom Boonsue, Ismael O. Jamora and David V. Cole, Point Pleasant. Alternates, Young Choi, Montrie Chaksupa and Mark Cheng, Point Pleasant.

**McDOWELL** (3)—Delegates, Muthusami Kuppusami, Arthur Allen Carr and Ray E. Burger, Welch. Alternates, Richard O. Gale and Bernard M. Swope, Welch; and Ross M. Patton, Gary.

**MERCER** (7)—Delegates, David F. Bell, Jr., and J. Elliott Blaydes, Jr., Bluefield; Frank J. Holroyd, Princeton; John J. Mahood, Bluefield; Sam Milchin, Bluefield, Virginia; Lawrence J. Pace, Princeton; and Edward M. Spencer, Bluefield.

**MINGO** (2)—Delegates, Arthur E. Levy and Russell A. Salton, Williamson.

**MONONGALIA** (14)—Delegates, Isaiah A. Wiles, W. Gene Klingberg, Barbara Jones, Herbert E. Warden, William A. Neal, Stanley J. Kandzari, Roger E. King, Bette G. Hinton, George A. Curry, Donald C. Carter, James M. Stevenson, Margaret I.

Stemple and Ralph W. Ryan, Morgantown. Alternates, Lawrance S. Miller, David A. Stoll, Ronica Kluge, Richard B. Knapp, David M. Morgan, Charles A. White, Robert L. Smith, Carl C. Barger, Stanley Roy Shane, John W. Traubert, Nathaniel F. Rodman, Jr., Jeanne A. Rodman, Barbara Tenney and Robert H. Waldman, Morgantown.

**OHIO** (10)—Delegates, R. U. Drinkard, John P. Franz, R. Alan Fawcett, David A. Kappel, Robert J. Reed III, Jess S. Renedo, Robert R. Weiler, Harry S. Weeks, Jr., Robert S. Robbins and Milton E. Nugent, Wheeling. Alternates, William F. Park, Charles V. Porter, William P. Sinclair, Alan Marshall Ruben, M. D. Reiter, John J. Battaglino, Alfred D. Ghaphery, Paul R. Hedges, James C. Durig and John W. Kennard, Wheeling.

**PARKERSBURG ACADEMY** (8)—Delegates, Bill M. Atkinson, Harry Shannon, William E. Gilmore, Robert F. Gustke, Paul G. Modie, Jr. and A. Paul Brooks, Parkersburg; Michael J. Lewis, St. Marys; and Jack J. Stark, Belpre, Ohio.

**POTOMAC VALLEY** (3)—Delegates, Sadtha Surattanont and Robert R. Brown, Romney; and Kanai L. Das, Petersburg. Alternates, Howard J. Maxwell, Petersburg; Robert W. McCoy, Jr., Keyser; and Alfred M. Palmer, Augusta.

**PRESTON** (2)—Delegates, Thomas A. Haymond, Masontown; and Del Roy R. Davis, Kingwood. Alternates, William H. Harriman, Jr., Terra Alta; and John W. Trenton, Kingwood.

**RALEIGH** (7)—Delegates, Richard D. Richmond, Joseph A. Maiolo, William D. McLean, Walter E. Klingensmith, Richard G. Starr, R. C. Jereza and Lamberto C. Maramba, Beckley. Alternates, Grover C. Hedrick, Jr., Jose L. Oyco, Worthy W. McKinney, Iligino Salon, Emilio H. Delgado, William H. Wanger and R. James Yates, Beckley.

**SUMMERS** (2)—Delegates, Buford W. McNeer and Jack D. Woodrum, Hinton.

**TYGART'S VALLEY** (5)—Delegates, James William Woodford, Philippi; Michael M. Stump, Robert R. Rector and James B. Magee, Elkins; and Samuel M. Santibanez, Grafton. Alternates, A. Kyle Bush, Philippi; Christopher Z. Villaraza, Grafton; and Hugh H. Cook, Jr., and Jerome C. Arnett, Jr., Elkins.

**WETZEL** (2)—No delegates or alternates designated.

**WYOMING** (2)—Delegates, Frank J. Zsoldos and Ross E. Newman, Mullens. Alternate, George F. Fordham, Mullens.

## *Reception Committee*

KENNETH G. MACDONALD, SR., *Chairman*

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Richard E. Flood
Stephen D. Ward
Vernon E. Duckwall
C. A. Hoffman
Joe N. Jarrett

William L. Mossburg
Harry Shannon
Carl J. Roncaglione
Carl R. Adkins
John B. Markey
George A. Curry

D. Sheffer Clark
Joseph A. Smith
J. C. Huffman
Worthy W. McKinney
Joseph T. Skaggs
Charles E. Andrews

Robert D. Hess
Arthur E. Levy
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Leo H. T. Bernstein
William E. Gilmore
Seigle W. Parks
Robert R. Rector

Harry S. Weeks, Jr.
Echols A. Hansbarger, Jr.
Arthur A. Abplanalp
James W. Lane
John A. Belis
Stanley J. Kandzari

John J. Mahood
Jack Leckie
Warren D. Elliott
William A. Welton
Nolan C. Parsons, Jr.
Harvey D. Reisenweber

Charles E. Haislip
Richard A. Hawkins
John F. I. Zeedick
Jimmie L. Mangus
Winfield C. John
Donald C. Carter

Isaiah A. Wiles
Mildred Mitchell-Bateman
Charles C. Weise
Florence K. Hoback
William L. Neal
Herbert H. Pomerance
T. Keith Edwards
M. V. Kalaycioglu

## Official Program
## AUXILIARY
### to the
### West Virginia State Medical Association
### 56th Annual Meeting
### THE GREENBRIER
### White Sulphur Springs
### August 20-23, 1980

### WEDNESDAY AFTERNOON
**August 20**

3:00—First Session of the House of Delegates, West Virginia State Medical Association (Chesapeake Hall).

Address by Robert B. Hunter, M.D., President, American Medical Association.

4:00—Pre-Convention Board Meeting, Mrs. D. Sheffer Clark, President, presiding (Fillmore-Van Buren Rooms).

### WEDNESDAY EVENING

6:30-7:30—President's Reception for Honor Guests (Old White Patio).

### THURSDAY MORNING
**August 21**

9:00—Formal Opening of the 113th Annual Meeting of the West Virginia State Medical Association (Theater).

"The Thomas L. Harris Address"

William R. Barclay, M.D., Chicago, Editor, Journal of the American Medical Association.

(Auxiliary Members are Invited to Attend).

9:45—Formal Opening of the Convention, Mrs. D. Sheffer Clark, President, presiding (Fillmore-Van Buren Rooms).

Invocation, Pledge of Loyalty, and Pledge to Flag.

Introduction of Honor Guests.

Presentation of Stephen D. Ward, M.D., President, West Virginia State Medical Association.

Introduction of Convention Chairman — Mrs. M. Bruce Martin.

Roll Call of Delegates — Mrs. Charles E. Turner, Recording Secretary.

Convention Rules of Order — Mrs. M. Bruce Martin, Parliamentarian.

Report of the 1979 Convention Reading Committee — Mrs. J. Dennis Kugel.

Treasurer's Report — Mrs. J. Dennis Kugel.

In Memoriam — Mrs. Lynnwood D. Zinn.

Credentials and Registration — Mrs. Wilson Smith.

Keynote Address — Mrs. John F. Vaughan, President, American Medical Association Auxiliary.

Recommendations from Pre-Convention Board Meeting — Mrs. D. Sheffer Clark.

Report of the Revisions Committee — Mrs. M. Bruce Martin.

New Business and Announcements.

Report of the 1980 Nominating Committee, First Reading — Mrs. Joseph T. Mallamo.

Election of 1981 Nominating Committee.

Reports of Officers and Standing Committee Chairmen (These will not be read, but are published in the Annual Reports Book).

Presentation of Regional Directors:

Eastern Region—Mrs. Herbert E. Warden.

Northern Region—
Mrs. M. V. Kalaycioglu.

Western Region—Mrs. Nazem Abraham.

Southern Region—Mrs. T. Keith Edwards.

Central Region—Mrs. Logan W. Hovis.

Recess.

### THURSDAY AFTERNOON

2:00—Bridge (Trellis Lobby). Kanawha County, Host Auxiliary. Mrs. J. L. Mangus, Chairman.

Golf. Monongalia County, Host Auxiliary. Mrs. George A. Curry, Chairman. (Golf may be played either Thursday or Friday afternoon.)

### FRIDAY MORNING
**August 22**

8:00—Past Presidents' Breakfast, Mrs. Joseph T. Mallamo, Past President, presiding (Virginia Room).

9:45—Second General Session—Mrs. D. Sheffer Clark, President, presiding (Fillmore-Van Buren Rooms).

Introduction of Honor Guests.

Roll Call of Delegates — Mrs. Charles E. Turner.

Address—Mrs. Raymond M. Yow, President, Southern Medical Association Auxiliary.

Convention Announcements — Mrs. M. Bruce Martin.

Report of Convention Committees:

Finance — Mrs. J. L. Mangus.

Credentials and Registration — Mrs. John J. Brandabur and Mrs. Frank M. Peck.

Press and Publicity — Mrs. Larry D. Curnutte.

Presentation of AMA-ERF Awards — Mrs. Robert S. Robbins and Mrs. John W. Kennard, State Co-Chairmen, to: John E. Jones, M. D., Dean, West Virginia University School of Medicine; and Robert W. Coon, M. D., Dean, Marshall University School of Medicine.

Unfinished Business.

Report of the 1980 Nominating Committee, Second Reading — Mrs. Joseph T. Mallamo.

Election of Officers.

Installation of Officers — Mrs. John F. Vaughan, President, American Medical Association Auxiliary.

Presentation of President's Pin and Gavel — Mrs. D. Sheffer Clark.

Presentation of Past President's Pin — Mrs. Joseph T. Mallamo.

Inaugural Address — Mrs. Gary G. Gilbert.

Announcements.

Adjournment.

## FRIDAY AFTERNOON

2:00—Tennis Tournament. Kanawha County, Host Auxiliary. Mrs. Alfredo C. Velasquez and Mrs. Thomas J. Janicki, Co-Chairmen.

Golf. Monongalia County, Host Auxiliary Mrs. George A. Curry, Chairman.

(Golf may be played either Thursday or Friday afternoon.)

## FRIDAY EVENING

9:30—Monte Carlo Night. Cabell County, Host Auxiliary. Mrs. Charles E. Turner, Chairman (Chesapeake Hall). (Tickets may be purchased at the registration desk.)

## SATURDAY MORNING

### August 23

10:00—Postconvention Board Meeting — Mrs. Gary G. Gilbert, President, presiding (Fillmore-Van Buren Rooms).

## SATURDAY AFTERNOON

2:30—Second and Final Session of the House of Delegates, West Virginia State Medical Association (Chesapeake Hall).

Presidential Address — Stephen D. Ward, M. D.

Installation of L. Walter Fix, M. D., as 1980-81 President of the West Virginia State Medical Association.

(Auxiliary Members are Invited to Attend.)

## SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association and its Auxiliary (Colonial Hall Terrace).

# SCIENTIFIC EXHIBITS

### DEPARTMENTS OF PEDIATRICS AND RADIOLOGY, WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE

"MALPOSITION OF THE HEART." Various types of cardiac malposition are illustrated, using diagramatic and x-ray representations of each type. These include examples of dextrocardia, mesocardia and levocardia, and the relationship of each to visceral situs.

William A. Neal, M. D., Associate Professor of Pediatrics, and Orlando F. Gabriele, M. D., Professor and Chairman, Radiology.

### THE MYERS CLINIC—BROADDUS HOSPITAL

"DERMATOLOGIC DIAGNOSIS IN OUT-PATIENT PEDIATRICS: CAN YOU IDENTIFY THESE 10 CASES?" This exhibit presents 10 cases of pediatric dermatology. All cases are presented with color slides of the rash or skin lesions, and symptoms, and then the diagnosis is given so that the physician can use this method to refresh his acuity in out-patient pediatric dermatology.

Elvin G. Kreider, M. D., Medical Director, and J. Richard Crawford, Director of Photography.

### NATIONWIDE INSURANCE—MEDICARE

"MEDICARE OPERATIONS." Nationwide's district Medicare managers will be available to discuss your Medicare questions. Copies of your allowable charge profile also will be available at Nationwide's booth.

Preston Jolley, Field Operations Manager; Jim Cuppy, Field Services Manager; Rodney Parker, District Manager, Charleston, and Don Harper, District Manager, Clarksburg.

### OFFICE OF HEALTH SERVICES RESEARCH, DEPARTMENT OF COMMUNITY MEDICINE, WEST VIRGINIA UNIVERSITY

"A MODEL REFERRAL MECHANISM FOR PRIMARY CARE CLINICS." Our researchers were able to identify a serious lack of standard procedures and a weak process of documentation of information in referrals from nearly a dozen West Virginia primary health care centers to urban medical specialists. Based on experience with primary care physicians and medical specialists, a model referral mechanism was devised and tested for five months in six rural medical facilities in order to determine whether the procedures would effectively improve the exchange of information and continuity of care during referrals. The results strongly suggest that the model procedures can be applied practically to: Resolve documentation problems; improve the quality of the referral process; improve continuity of care, and standardize the management of referrals in primary care medical facilities.

Edward M. Bosanac, Assistant Professor, and R. John C. Pearson, M. B., Professor and Department Chairman.

### SOUTHERN MEDICAL ASSOCIATION

"SOUTHERN MEDICAL ASSOCIATION DIAL ACCESS SYSTEM." The Dial Access System makes available, without charge, the most recent diagnostic and therapeutic information on specific problems in seven disease categories. The service can be used by dialing the appropriate telephone number and requesting, by number, any of the topics listed in the seven catalogues. The seven disease categories are: Cancer; Diabetes and Endocrinology; Infectious Diseases; Obstetrics and Gynecology; Gastroenterology; Arthritis and Rheumatism; and Psychotherapeutics.

Roy B. Evans, Jr., Executive Director.

### UNITED STATES AIR FORCE HEALTH PROFESSIONS RECRUITING

"USAF MEDICAL PROGRAMS." A display of opportunities for physicians to practice their profession with the USAF Medical Corps. If you're a physician who at one time or another has considered a change, then take a look at the Air Force facilities and programs. We in the USAF believe ours is one of the finest health care programs in the nation, and that it offers many unusual professional, as well as personal, opportunities.

TSgt. Dan Webster, Health Professions Recruiter.

### UNITED STATES ARMY MEDICAL DEPARTMENT

"U. S. ARMY MEDICAL DEPARMENT." Physician Placement Service for the entire U. S. Army Medical Department. We will be providing information about the Health Scholarship Program for medical students, internship/residency/fellowship opportunities, and the plethora of placement possibilities for physicians in all specialtes.

Major (Dr.) Robert R. Sellards, AMEDD Counselor.

### WEST VIRGINIA CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

"SPEAK UP FOR CHILDREN." An exhibit stressing advocacy for children ongoing at this time, and including a display designed to be a follow-up to the International Year of the Child.

Herbert H. Pomerance, M. D., Chapter Chairman; Gilbert A. Ratcliff, Jr., M. D., Associate Chairman, and Kenneth L. Wible, M. D., Secretary-Treasurer.

**WEST VIRGINIA DEPARTMENT OF HEALTH**

I. "PATIENT PACKET INSERTS;" and II. "QUIZAMATIC QUESTIONS AND ANSWERS ABOUT LABELS AND NUTRITION."

Polly Diller, Director of Volunteer Services.

**WEST VIRGINIA DISABILITY DETERMINATION SECTION, FEDERAL SOCIAL SECURITY ADMINISTRATION**

"DISABILITY EVALUATION UNDER SOCIAL SECURITY." Defines medical criteria used to determine disability under Social Security, with brief outline of adjudication process. Definitions and process also apply to people filing for disability under the Supplemental Security Income (SSI) provision. Handout material will also be available. Will discuss with interested physicians need for consultants in many specialties throughout West Virginia.

William S. Herold, M. D., Chief Medical Consultant, and Victor B. Clark, Medical Relations Officer.

**WEST VIRGINIA HEALTH SYSTEMS AGENCY**

"HSA IS PEOPLE." Brochures on health planning and implementation in West Virginia.

Isaiah A. Wiles, M. D., Consultant.

**WEST VIRGINIA MEDICAL INSTITUTE, INC.**

"DISPLAY OF PRACTICE PATTERNS." The West Virginia Medical Institute, Inc., will demonstrate practice patterns in common diagnoses. The demonstration will show how information can be developed which is of value in group discussions and in monitoring the quality and appropriateness of care. A working computer terminal will be available for on-line data inquiries with limited access for hospital patterns. Members of the Institute may request a visual display of selected statistics. Your comments and suggestions concerning Institute activities will be welcomed.

Harry S. Weeks, Jr., M. D., President, and Betty C. Kirkwood, Executive Director.

**WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE**

"CONTINUING MEDICAL EDUCATION AT WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE." Materials will be available regarding the 1980-81 program of Continuing Medical Education offered by the WVU School of Medicine. The program is accredited by the Liaison Committee on Continuing Medical Education (LCCME) and American Medical Association, and offers a variety of CME opportunities to the practicing physician.

Robert E. Kristofco, Assistant Coordinator, Continuing Medical Education.

**WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE**

"FOURTH-YEAR CURRICULUM HIGHLIGHTS." Information will be available on the nature of the fourth-year medical student curriculum at West Virginia University School of Medicine and its affiliated institutions. A review of student activity in the 1979-80 academic year also will be presented.

Robert E. Kristofco, MS IV Curriculum Coordinator.

**WEST VIRGINIA WORKMEN'S COMPENSATION FUND**

"WEST VIRGINIA WORKMEN'S COMPENSATION FUND." This display emphasizes the involvement of the medical community in almost every aspect of a workmen's compensation claim. The Fund is heavily dependent on the medical vendors throughout the State; therefore, it is essential that the lines of communication remain open and clear.

# ANNUAL REPORTS

## Medical Education and Hospitals Committee

The activities of the Committee were confined during the 1979-80 year to the area of accreditation of continuing medical education programs.

A total of eight continuing medical education site surveys, which were re-surveys, has been conducted through the Committee on Medical Education and Hospitals since August 1, 1979, resulting in full four-year accreditation of five hospitals and two specialty societies. One hospital which had been granted a one-year provisional in 1978 was not approved for re-accreditation following a re-survey in September, 1979, pending continued CME program development.

One physician only, usually the chairman of the previous three-member survey team, conducts a re-survey. The eight re-surveys held since last August, the dates, and the physicians conducting the surveys follow:

Ohio Valley Medical Center and Wheeling Hospital, Wheeling, August 1, 1979, Dr. Thomas J. Beynon of Weirton; Herbert J. Thomas Memorial Hospital, South Charleston, September 18, 1979, Dr. Dennis S. O'Connor of Huntington; St. Francis Hospital, Charleston, November 13, 1979, Dr. R. Wade Ortel of Wheeling; St. Mary's Hospital, Huntington, January 16, 1980, Dr. William O. McMillan, Jr., of Charleston; West Virginia Chapter, American College of Surgeons, May 2, 1980, The Greenbrier, White Sulphur Springs, Dr. C. Richard Daniel of Beckley; Weirton Medical Center, Weirton, January 11, 1980, Dr. John W. Traubert of Morgantown; West Virginia Academy of Ophthalmology and Otolaryngology, April 21, 1980, The Greenbrier, White Sulphur Springs, Dr. R. James Yates of Beckley, and Beckley Appalachian Regional Hospital, Beckley, May 2, 1980, Dr. William J. Echols of Huntington.

All of the above, with the exception of Herbert J. Thomas Memorial Hospital, where program development is continuing, were granted full, four-year re-accreditation by the Committee.

It is interesting to note that the re-survey of Beckley Appalachian Regional Hospital on May 2, 1980, was the fourth survey for that hospital, the first hospital to be surveyed (May 23, 1973) under the State Medical Association's accreditation program.

Since May of 1973, 12 hospitals and four specialty societies and organizations have been surveyed. Including re-surveys, a total of 41 site surveys, with 27 individual state physicians serving as team members, has been conducted. Eleven hospitals and four specialty societies and organizations have been re-surveyed. The Reynolds Memorial Hospital, Glen Dale, was granted a two-year provisional accreditation for a newly developing program by the Committee on March 3, 1979 (full accreditation is for four years).

Following is the complete list of original hospital and group surveys (with re-surveys not shown) since the beginning of the accreditation program:

*Beckley Appalachian Regional Hospital, May 23, 1973.*

*Veterans Administration Center, Martinsburg, March 26, 1974.*

*West Virginia Academy of Ophthalmology and Otolaryngology, April 18, 1974.*

*West Virginia Chapter of the American College of Surgeons, May 2, 1974.*

*St. Mary's Hospital, Huntington, November 20, 1974.*

*Charleston Area Medical Center, January 15-16, 1975.*

*West Virginia Obstetrical and Gynecological Society, September 26, 1975.*

*Broaddus Hospital-Myers Clinic, Philippi, December 3, 1975.*

*Ohio Valley Medical Center and Wheeling Hospital, Wheeling, February 11-12, 1975.*

*Fairmont Clinic, November 1976.*

*Mid-Ohio Valley Continuing Medical Education Committee (Camden-Clark Memorial Hospital, St. Joseph's Hospital Center and Parkersburg Academy of Medicine), March 30-31, 1977.*

*Herbert J. Thomas Memorial Hospital, South Charleston, September 14, 1977.*

*St. Francis Hospital, Charleston, February 17, 1978.*

*Weirton Medical Center, February 9, 1978.*

*Jackson General Hospital, Ripley, May 26, 1978.*

*Reynolds Memorial Hospital, Glen Dale, March 3, 1979.*

The Subcommittee on Accreditation is charged with reviewing survey team reports of programs within the state seeking accreditation and recommending approval or disapproval to the entire Committee on Medical Education and Hospitals. The members of the subcommittee are Drs. T. Keith Edwards of Bluefield, George M. Kellas of Wheeling and Mary Lou Lewis of Charleston.

A mail ballot is used for members of the Committee to approve or disapprove the recommendation of the survey team and the subcommittee. A summary of the team report accompanies each mail ballot.

Hospitals and groups accredited by the State Medical Association, which serves as an accrediting body for the American Medical Association, are eligible to grant credit in Category 1 of the AMA's Physician's Recognition Award for their CME programs.

Respectfully submitted,

R. James Yates, M. D.
*Chairman*

July 3, 1980.

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## Insurance Committee

In 1944, the West Virginia State Medical Association Group Insurance Program was initiated as a means of providing a valuable membership benefit to our colleagues. The continued growth of this Program remains a source of confidence and security to all participants.

We have been most fortunate in enjoying the benefits of knowledgeable and conscientious administration since the inception of this Program. Today, we have eight plans in effect, each designed to meet the unique requirements of our profession and to protect our families and employees. Over the years, your Insurance Committee has worked with the Administrator to assure continued attention to the timeliness of our sponsored coverages.

As in the past, all administration and most of the claims are accomplished locally. This capability is one advantage of having a locally-based Administrator — we can assure speedy response to our questions and claims, and also perpetuate the personalized service we have come to expect. Despite growth, our Administrator continues to empasize personalized handling, including processing of applications, billing and collections, and review and payment of claims. Members are regularly advised of coverage available to them through the State Medical Association through mailings which help ensure the continued growth and healthy status of our Program. It remains today one of our most valuable membership benefits.

As is our policy, your Insurance Committee is including an overview of each of the Plans available. We encourage you to read these descriptions carefully with an eye to your existing coverages.

### GROUP INSURANCE PORTFOLIO

*Term Life Insurance* — Available in units of $10,000 to a maximum of $100,000. Optional coverage for spouse and children in lesser amounts is available. This year, we were granted a rate reduction due to experience ratings.

*Hospital Money Plan* — Offers a choice of benefits — up to $100 a day for each day of hospital confinement — for a member and spouse. Dependent children may be insured up to $50 a day. This Plan was developed to help with the "over and above" expenses associated with a stay in the hospital.

*Office Overhead Expense* — Helps to cover routine office expenses in the event you are disabled. These expenses include rent, utilities, depreciation, employees' salaries and other normal operating costs. This Plan offers coverage up to $5,000 a month — and is tax deductible.

*Long-Term Disability* — Provides benefits up to $500 a week when you are totally disabled. Three benefit plans exist, and you may further tailor a plan by selecting one of the self-insured waiting periods. Additionally, this Plan includes an optional recovery benefit rider which provides a lump sum at such time as a disabled physician resumes practice. Disability coverage for employees of an insured member is also available for up to $100 a week in benefits.

*Family Major Hospital* — Protects you from the disastrous financial pressure of a serious accident or major illness in the family. The Family Major Hospital Plan can help cover these expenses, with up to $30,000 in benefits.

*Accidental Death & Dismemberment* — Provides 24-hour protection, 365 days a year, and has a maximum limit of $100,000. This type of catastrophic protection follows you on and off the job, anywhere in the world, including full protection as a passenger on commercial airlines.

*Coordinated Investment Service* — Specifically designed for HR-10, offers mutual funds, fixed or variable annuities, and split funds.

*Group Professional Liability Insurance* — offers up to $1,000,000 Professional Malpractice

protection, including umbrella excess liability limits over auto, office and personal coverages.

**Professional Liability Program**

The Professional Liability Program sponsored by the Association and written by Ætna Life & Casualty is now in its eighth year of operation in the State. During this period an attempt has been made to introduce changes that will make the program current and viable.

An investment income credit of six per cent of the primary professional liability premium was included in the dividend calculation this year. Two dividends were returned during the past year to participants totaling $797,977. A total of $2,460,134 has been returned in dividends since the program's inception.

Other beneficial changes for the year involved the contingency expense provision, defendants' reimbursement coverage, Med Pak coverage and reduction of rates for physicians in their first and second year of private practice.

A rate increase was received which averaged 16.9 per cent. When combined with the other changes, total program revenue increased 15.3 per cent.

An upward swing of frequency and severity continues in medical malpractice claims for the State. The reports for the past four calendar quarters show new cases received of 25, 47, 46 and 80, respectively. The current prediction is that over 200 West Virginia physicians will be sued during the next year. Even of more concern is the severity aspect — the amount needed to settle an average claim. The average payment for the cases settled during the January-to-March quarter of this year was $32,743. The average for all 1979 was $19,239 per case. As of March 31, 1980, the program had 346 pending cases, and reserves totalled $8,860,515. By comparison, the situation on March 31, 1979, showed 206 pending cases and reserves of $4.1 million.

A Risk Management Program was launched by the State Medical Association and Ætna during the past year in order to pursue loss prevention aggressively. A newsletter to provide information to the program's physicians has been developed as part of the effort. Various presentations have been made by Ætna's Account Supervisor to address the problems being encountered. Medical records have received a great deal of attention from physician groups. Their role as defense tools must be clearly understood.

The District Claim Review Panels continue to be an important part of the total Risk Management Program. New members have been added to the panels, and the panels are actively involved in assisting Ætna's defense counsel with the medical aspects of specific cases. It is an educational forum that has proved to be very helpful.

Everyone's commitment and involvement are needed if we are to weather the events to come and have a successful program. It is suggested that success will be experienced in direct proportion to the commitment and involvement made.

Respectfully submitted,

Lyle D. Vincent, M. D.,
*Chairman*

William R. Barton
James L. Bryant
John T. Chambers
David V. Cole
R. U. Drinkard
L. Walter Fix
H. Summers Harrison
James A. Heckman
C. A. Hoffman
Edward Jackson
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# WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

# EQUAGESIC® CIV

## (meprobamate and ethoheptazine citrate with aspirin) Wyeth

**EQUAGESIC—Abbreviated Summary**

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

**CONTRAINDICATIONS:** Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

**WARNINGS:** Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination

**USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a women of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.**

**Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.**

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under

**PRECAUTIONS:** Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

**ADVERSE REACTIONS:** A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

**OVERDOSE:** Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

**DESCRIPTION:** Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication.

**Wyeth Laboratories**
Philadelphia, Pa 19101

# WHY NOT WYGESIC® C IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

**WYGESIC—Abbreviated Summary**
**INDICATION:** For the relief of mild-to-moderate pain
**CONTRAINDICATION:** Hypersensitivity to propoxyphene or to acetaminophen
**WARNINGS:** CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)
**DRUG DEPENDENCE:** Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
**USAGE IN AMBULATORY PATIENTS:** Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g driving a car or operating machinery Patients should be cautioned accordingly
**USAGE IN PREGNANCY:** Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards
**USAGE IN CHILDREN:** Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
**PRECAUTIONS:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol
**ADVERSE REACTIONS:** The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported
**DRUG INTERACTIONS:** Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
**MANAGEMENT OF OVERDOSAGE:** SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
**TREATMENT:** Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e.g caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and/or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness Appropriate literature should be consulted for further information (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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# WVU Medical Center –News–

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## Doctor Traubert Elected Chief Of Staff

Dr. John W. Traubert, Professor and Chairman of the Department of Family Practice, has been elected Chief of the West Virginia University Hospital medical and dental staff.

Doctor Traubert, a member of the School of Medicine faculty since 1973, succeeds Dr. Barbara Jones, Professor and Assistant Chairman of Pediatrics. He is a 1956 graduate of WVU and received his master of science and M. D. degrees at Ohio State University. He formerly practiced in Wellsburg.

New Assistant Chief of Staff at University Hospital is Ellen E. Hrabvosky, M. D., Associate Professor of Surgery and Pediatrics, and the Secretary of Staff is Ronica M. Kluge, M. D., Associate Professor of Medicine and Head of the Infectious Diseases Section.

Others named to the Staff Executive Committee included Drs. Ralph O. Dunker, neurosurgery; Jesse J. Jenkins III, pathology and pediatrics; Edwin J. Morgan, Director of the WVU Health Service; William A. Neal, pediatrics, and Peter C. Raich, oncology.

All were named recently at the hospital's annual staff election meeting.

## WVU Hospital Administrator Holds National Post

Eugene L. Staples, Administrator of West Virginia University Hospital, has been named Chairman of the national Liaison Committee on Graduate Medical Education, the first non-physician to hold the post.

The committee is responsible for reviewing and accrediting all programs of graduate medical education, most of which lead to specialty certification.

The LCGME has jurisdiction over 5,200 programs at hospitals and medical centers throughout the United States, where 86,000 resident physicians are taking their post-doctoral training. It accredits 22 medical specialties.

Staples has been a member of the committee for the past six years. He had served as a member of the Executive Committee and as Chairman of the Finance Committee during the preceding year.

LCGME has four members each from the American Board of Medical Specialties, the American Medical Association and the Association of American Medical Colleges, and two members each from the American Hospital Association and the Council of Medical Specialty Societies.

**WVU Assistant Swim Coach and graduate student William Brubaker of Mechanicsburg, Pennsylvania, in a cooperative biomechanics study, moves freestyle through the water in WVU's natatorium while tethered to the edge of the pool by a cable and force-measuring device around his waist. Results of the propulsive forces he generates are monitored by, from left, clockwise, Kevin Gilson, Physical Education Professor and WVU Swim Coach; R. Bruce Martin, M.D., Associate Professor of Orthopedic Surgery; Rachel A. Yeater, Assistant Professor of Physical Education, and Mary Kay White, physical education graduate student from Fairmont.**

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  Covers you and your family up to $30,000 per person
- ☐ HOSPITAL MONEY PLAN
  Pays you up to $100.00 per day when you or a member of your family is hospitalized
- ☐ LOW-COST LIFE INSURANCE
  In units of — $10,000 — $20,000 — $30,000 — $40,000 — $50,000
- ☐ $100,000 ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
  Around the clock protection — 24 hours a day . 365 days a year . . worldwide
- ☐ OFFICE OVERHEAD DISABILITY POLICY
  Pays your office expense up to $3,500 per mo while you are disabled
- ☐ A MILLION DOLLAR CATASTROPHE LIABILITY POLICY
  Covers: Malpractice — Home — Personal — Auto Liability

Name_____

Address_____ Phone # _____

# Third-Party News, Views and Program Concerns

## Open Letter

*Here is an open letter to physicians from Gretchen O. Lewis, West Virginia's recently-appointed Workmen's Compensation Commissioner*:

You, the members of the medical profession in West Virginia, directly influence the single most important aspect of the administration of Workmen's Compensation. You provide to us the medical information upon which virtually all decisions are based.

Since coming to the Fund some 16 weeks ago, I have made many observations and taken some action which I would like to share with you. But first, some insight into my background and perspective may be helpful.

I am the first non-attorney since the early 1940s to serve in the capacity of Commissioner. This difference in education, training and exposure is evidenced in my philosophy and approach to Workmen's Compensation. The Fund must be managed as the multi-million dollar insurance company that it is. Only through enlightened and professional management can we accomplish our mission of providing to the injured worker prompt and proper benefits in the form of replacement of lost earnings, the best medical care, and rehabilitation, if necessary.

Those of you who work with the Fund may have already noticed the results of my first efforts — speeding up medical invoice payments. We are now paying bills for medical services in less than 30 days. By way of information, we pay for reasonable and necessary medical treatment arising from a work-related injury at the physician's usual and customary rate. We are a government agency in the sense that the Fund is administered through the state government. However, we receive no state or federal tax dollars and are funded entirely by employer premiums. We are an insurance agency that is housed in state government with the fundamental purpose of providing benefits to the workers of West Virginia who have sustained injuries on the job.

In my first weeks as Commissioner, I established a Claims Service Division to replace the numerous units who responded to inquiries from claimants, employers, physicians, legislators and congressional representatives. We now have a group of Workmen's Compensation experts who answer questions from our public on every aspect of the Fund's operation.

One of the next major areas of reorganization will be our Medical Division. It is in this regard that I solicit your ideas, comments and support for the imminent changes in the philosophy and operation of the Medical Division. We will move to a posture of claims management rather than one of reacting to computer reports and generating paper. We will in the future be requesting from you, as the attending physician or examiner, more substance and less form. It is imperative that the people in the Fund who are making legal and medical decisions have the benefit of your knowledge, experience, and opinion. If you are interested in participating in the Workmen's Compensation program, we are always in need of qualified examiners. Our response from the article in the May issue of *The West Virginia Medical Journal* was great and we are very appreciative of the use of this medium.

I will be attending the West Virginia State Medical Association Annual Meeting at the Greenbrier in August and will be accompanied by Joseph I. Stone, our primary liaison with the medical profession. We will bring an informative exhibit, which will be housed in Eisenhower Hall, and will be available to answer any questions that you may have. I look forward to meeting you there.

Sincerely,

Gretchen O. Lewis
Commissioner

# Rx: Air Force Medicine

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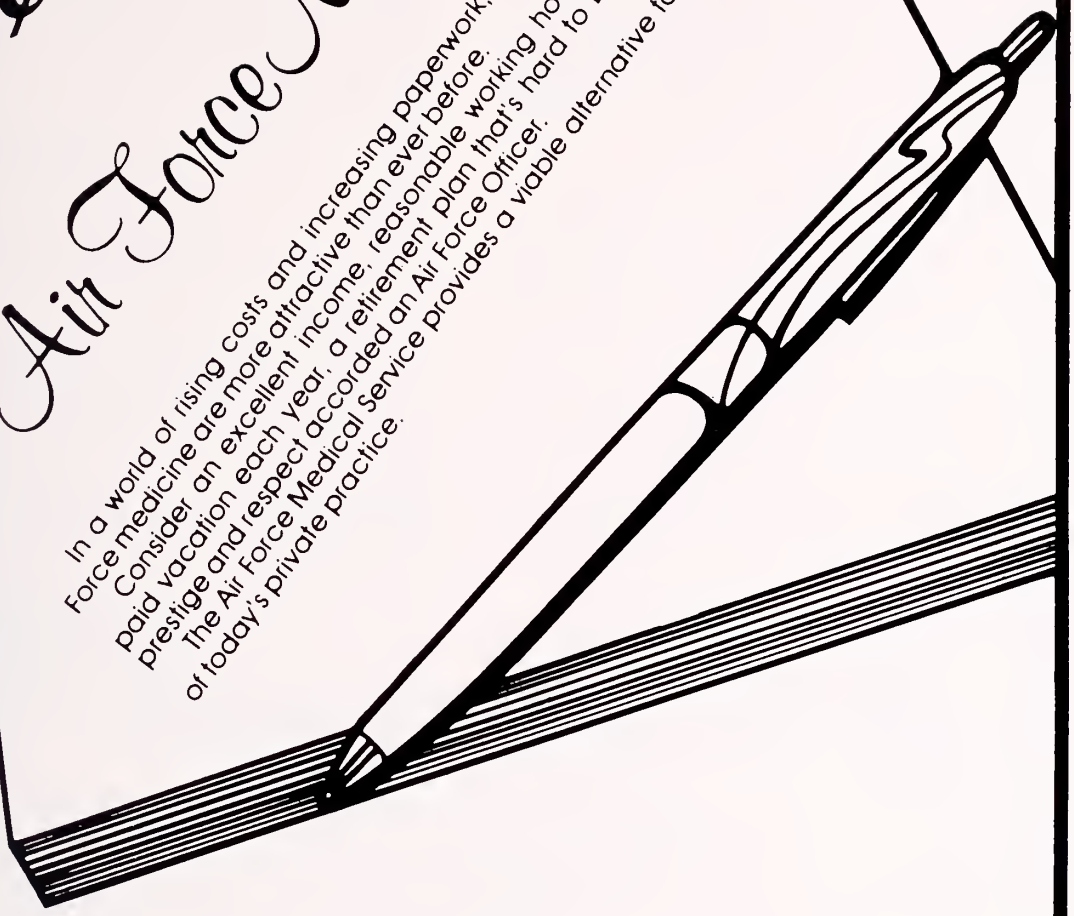

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# Obituaries

### REVERDY H. JONES, JR., M. D.

Dr. Reverdy H. Jones, Jr., Fairmont internist, died on June 2 at his home there. He was 66.

Doctor Jones formerly was associated with the Fairmont Clinic, and later became Chief of Medicine at the Veterans Administration Medical Center in Clarksburg.

While in Clarksburg he was President of the Harrison County Medical Society.

Doctor Jones served for five years with the U. S. Navy and the U. S. Marines during World War II, and was a volunteer physician in Vietnam for three months in 1969.

He began a private practice in Fairmont in 1978 after retiring from the VA hospital in Clarksburg.

A native of Portsmouth, Virginia, he was a Clinical Associate Professor of Internal Medicine at the West Virginia University School of Medicine.

Doctor Jones was graduated from Virginia Military Institute, and received his M. D. degree in 1943 from the University of Virginia. He interned at Lankenau Hospital in Philadelphia and completed a fellowship in internal medicine at the Mayo Clinic.

He was a member of the Marion County Medical Society, West Virginia State Medical Association, American Medical Association, American College of Physicians, and American College of Cardiologists.

Survivors include the widow; two sons, Reverdy H. Jones III of Houston, Texas, and Dr. Thomas E. Jones, Rochester, Minnesota; two daughters, Mrs. Robert Webb, Charlottesville, Virginia, and Mrs. P. Ronald Graziani, Fairmont; and one sister, Mrs. Henry MacKenzie, Portsmouth.

### NEW NAME AND ADDRESS

Under provisions of the state's revamped Medical Practice Act, the Medical Licensing Board of West Virginia became — on July 1 — the West Virginia Board of Medicine. The Board's address is Room 520, 1800 Washington Street, East, Charleston 25305, telephone (304) 348-2921.


## THE GOLDEN CLINIC

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J. E. Cunningham, D. O. (Mount Storm & Riverton Clinics)
M. C. Rosenberg, D. O. (Helvetia Clinic)
L. E. Soriano, M. D. (Marlinton Clinic)
P. M. Tanna, M. D. (Green Bank Clinic)

**EMERGENCY MEDICINE:**
R. H. Plummer, D. O.
A. M. Fuller, M. D.
F. A. Khan, M. D.

**FAMILY PRACTICE:**
L. H. Valliant, M. D.
H. E. W. Gregor, M. D.

**INTERNAL MEDICINE:**
**Gastroenterology:**
S. S. Masilamani, M. D.
**Allergy & Rheumatology:**
J. B. Magee, M. D.
**Cardiology:**
H. L. Jellinek, M. D.
P. W. Gregor, M. D.
**Metabolic & Endocrine Diseases:**
F. Becerra, M. D.
**Pulmonary Diseases:**
J. C. Arnett, Jr., M. D.

**OBSTETRICS & GYNECOLOGY:**
H. H. Cook, Jr., M. D.
J. F. de Courten, M. D.
J. J. Rizzo, M. D.
M. W. Strider, M. D.

**OPHTHALMOLOGY:**
J. N. Black, M. D.

**ORTHOPAEDIC SURGERY:**
J. G. Gomez, M. D.
D. R. Antonio, M. D.

**OTOLARYNGOLOGY (Facial Cosmetic and Reconstructive Surgery):**
N. Stronach, M. D.

**PATHOLOGY:**
M. M. Stump, M. D.

**PEDIATRICS:**
Y. J. Kwon, M. D.
R. J. Haas, M. D.

**RADIOLOGY:**
F. H. Abdalla, M. D.
H. Y. Mang, M. D.
C. P. O'Sullivan, M. D.

**SURGERY:**
**General, Thoracic & Vascular:**
J. A. Noronha, M. D.
W. B. Blum, M. D.
B. R. Blackburn, M. D.
R. A. Rose, M. D.

**UROLOGY:**
D. T. Chua, M. D.

# County Societies

### MARION

The Marion County Medical Society met on May 27 at the Fairmont Field Club.

Dr. Stephen D. Ward of Wheeling, President of the State Medical Association, was the guest speaker. He discussed the role of organized medicine in present-day medical practice, and the need for political action.—William L. Mossburg, M. D., Secretary.

* * *

### FAYETTE

The Fayette County Medical Society met on June 4 at Montgomery General Hospital.

A letter from the Oak Hill Baptist Church was read requesting a suggestion from the Medical Society as to how the Society's contribution to the Dr. Ivan H. Bush, Jr., Memorial Fund might be allocated.

Members present were notified that the Society is receiving minutes of the State Medical Association Council, and that a $100 dues increase is proposed for the State Medical Association. —Daniel B. Doyle, M. D., Secretary.

* * *

### PARKERSBURG ACADEMY

The Parkersburg Academy of Medicine met on May 14 at the Rosemar Supper Club.

Dr. K. Douglas Bower, Jr., of Morgantown spoke on "Athletic Injuries on the Playing Field." Doctor Bowers is an orthopedic surgeon and Team Physician for West Virginia University.—Bill M. Atkinson, M. D., Secretary-Treasurer.

* * *

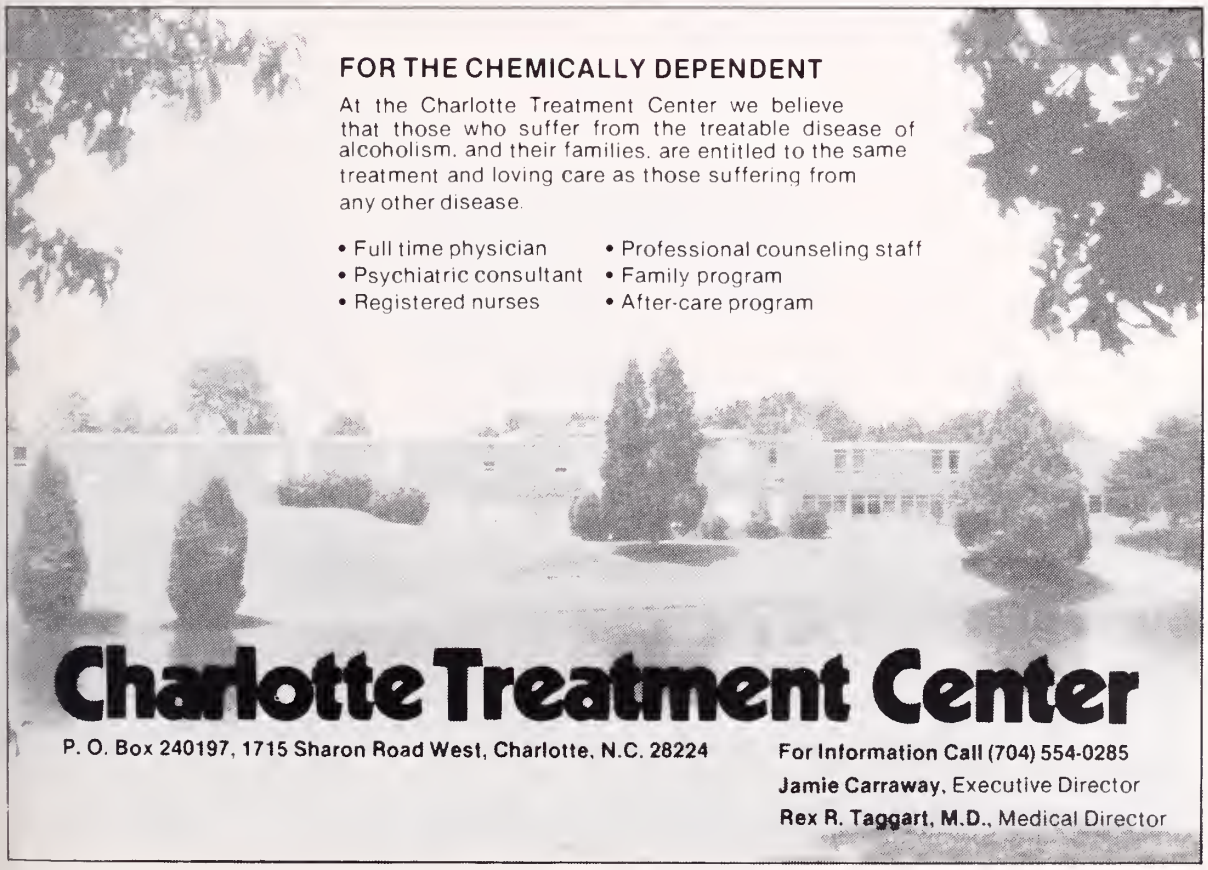
### CABELL

Dr. Stephen S. Amato of Morgantown was the guest speaker for the meeting of the Cabell County Medical Society on May 8. Doctor Amato is Associate Professor of Pediatrics and Director of Medical Genetics at West Virginia School of Medicine.

His talk reviewed the availability of genetics counseling in West Virginia, including the actual procedures and their effectiveness.

The Society met again, on June 12, at the Gateway Holiday Inn in Barboursville.

(Continued on next Page)

Dr. George J. Hill II, Professor and Chairman of Surgery, Marshall University School of Medicine, was the speaker.

Doctor Hill presented an enlightening discussion concerning cancer of the colon, with a review of the incidence, risk factors, methods of detection, methods of surgical treatment, and use of adjunctive chemotherapy in selected cases.—Robert C. Nerhood, M. D., and Charles E. Turner, M. D., Secretary.


**DIRECTOR OF MEDICAL AFFAIRS**

Applications are currently being accepted for this newly created position at Cabell Huntington Hospital, a progressive 300 bed, teaching hospital affiliated with Marshall University School of Medicine. The incumbent will assume broad responsibilities for coordinating the numerous activities, organizational functions and duties of the hospitals' medical and dental staff with more than 200 members. In this capacity as Director of Medical Affairs, he or she will work in close cooperation with the staff providing skill and leadership in the review and assessment of all quality assurance.

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For consideration, candidates must submit curriculum vitae not later than September 1 to:

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c-o Administrative Office
Cabell Huntington Hospital
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**FAMILY PHYSICIANS NEEDED**

Family Physicians needed for the Braxton County Area. A new 50-bed hospital, which is under Management Contract with the Charleston Medical Center, is scheduled to open December 1, 1980. The hospital will be located between Gassaway and Sutton. Excellent opportunity for growth. Community includes new schools, large recreational areas and a major highway (I-79). Contact: Earl L. Fisher, M. D., 710 Elk Street, Gassaway, WV 26624, Phone: 304-364-2401; or Michael A. King, Administrator, Box 74, Elk River Rt., Gassaway, WV 26624, Phone: 304-364-5890.

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**WANTED** — Obstetrician/Gynecologist needed to take over existing practice in progressive community centrally located between Parkersburg and Charleston. Nine year old modern 80 bed hospital with latest equipment and facilities. Hospital is willing to negotiate financial arrangements and office space. Excellent opportunity for young physician wishing to establish active practice. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

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Merrell-National, Inc. vi, *Insert*

Myers Clinic, The xvi

Pathology Associates Laboratory iv

Prince Medical Reference Laboratories ix

Roche Laboratories ii, iii, *Inside Back Cover, Back Cover*

Saint Albans Psychiatric Hospital xvii

United States Air Force xiii

United States Navy xvi

Wheeling Clinic, The xviii

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# The West Virginia Medical Journal

*Official Publication of the West Virginia State Medical Association*

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**MEMBER, WEST VIRGINIA PRESS ASSOCIATION, 1980**

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# CONTENTS

**Scientific Articles**

The Small Aortic Root—Robert A. Gustafson, M. D.; Alvin L. Watne, M. D.; William A. Neal, M. D.; and Thomas J. Tarnay, M. D. 225

Aspirin—Nothing Like It Or Nothing Better—John C. Krantz, Jr., Ph. D. 231

The New Medical Practice Act: Implications For Medical Discipline—William N. Walker, M. D.; and Patricia W. Williams, M. D. 233

**Scientific Department**

Medical Grand Rounds From The West Virginia University Medical Center (Recent Advances In Breast Cancer Management)—Edited by Irma H. Ullrich, M. D. 236

**The President's Page**

The Old Guard Changeth—L. Walter Fix, M. D., President, W. Va. State Medical Association 242

**Editorials**

A Vital Program 243

Winning The War 243

**General News**

14th Mid-Winter Clinical Conference 245

State Family Physicians To Meet 246

Continuing Education Activities 247

Family Practice Groups To Hold Joint Meet 248

New Association Members 249

State's New Medical Practice Act 250

AMA Opposes Proposed Medicaid Provision 251

Block Of Access To PSRO Documents Sought 252

**Special Departments**

WVU Medical Center News x

Third-Party News, Views, Program Concerns xii

Obituaries xv

Book Review xvii

Classified Section xx

Index To Advertisers xxii

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**ADVERSE REACTIONS** *Cardiovascular* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic* Urticaria, rash, ecchymosis, erythema. *Endocrine* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

**DOSAGE AND ADMINISTRATION** Tenuate (diethylpropion hydrochloride): One 25 mg tablet three times daily, one hour before meals and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

**OVERDOSAGE** Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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**References** 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon (Dillon), R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed. New York: Raven Press, 1978, pp. 391-404.

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# Overweight may not always be simple... complications can develop.*

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Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

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The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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## for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

## Librax®

**Please consult complete prescribing information, a summary of which follows:**

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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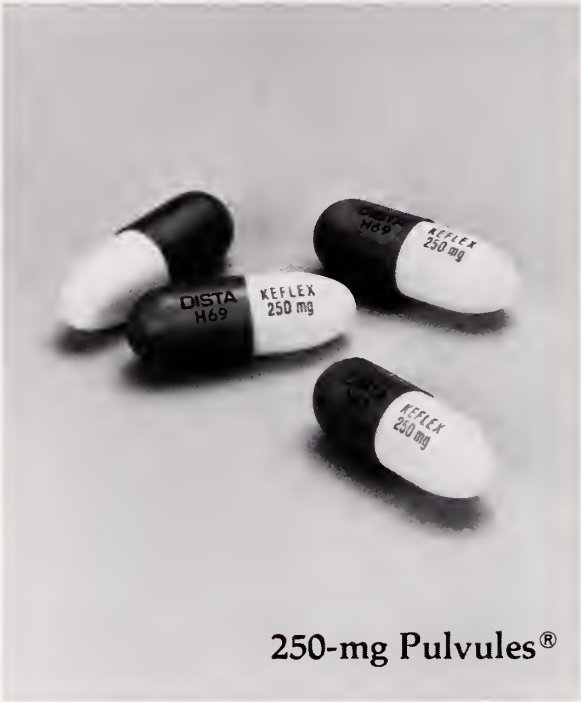


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# Health and Safety Tip

From the American Medical Association

535 North Dearborn Street/Chicago, Illinois 60610

## Air Travelers Face Jet Lag Fatigue

### Jet Lag Is Hazard

The most obvious contributor to stress in the modern world travel style is "jet lag fatigue."

An air traveler who departs from New York for Italy at 5:30 p.m. crosses seven time zones during a seven-hour flight, and arrives in Rome at 7:30 a.m. Rome time. But it is 12:30 a.m. in New York, the middle of the night for the traveler.

There is great variability in the effects of time zone changes and in one's speed of adjustment, the American Medical Association points out. The young adjust easily; older individuals more slowly.

Tourists planning months in advance for an overseas vacation should take conditioning exercises; a two to three-week program of walking up to three miles a day. Avoid the Bon Voyage party, unless it is given two or three days prior to departure.

In flight, remember that two drinks at cruising altitude are the equivalent of three or four on the ground. Eat moderately and drink sparingly. Get up and walk about the plane frequently.

The single most important requirement on arrival at the overseas destination is sleep and rest. A flight to Europe should be followed by a good night's sleep before sightseeing or business.

A simple formula often is used by tour groups. It calls for rest stops of a day after crossing four to six time zones, and two days after seven to ten zones. As crossings approach a complete reversal of the day-night cycle, three days of rest are welcomed by any traveler, particularly if in late middle age or afflicted with insomnia.

North-south flights cross no time zones, or only one, and should result in only normal fatigue.

A pretravel health review with your physician may help forestall health emergencies while on tour. There are some individuals who should not board long jet flights. These include women beyond the eighth month of pregnancy, infants less than two weeks old, individuals with contagious disease, those with large unsupported hernias, psychotics, acute respiratory infection patients (severe colds or flu), those with certain heart problems (ask your doctor), and poorly stabilized convalescent postoperative or handicapped people.

Jet lag fatigue may be held to a minimum by proper planning and proper rest on arrival.

August, 1980
Frank Chappell
Science News Editor
AMA

# getting back to business

# with symptomatic relief of moderate anxiety with depression

### Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

### Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

**for moderate anxiety with depression**

**dual-action Triavil®**

**containing perphenazine and amitriptyline HCl**

### Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

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*Please see the following page for a brief summary of prescribing information.*

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## by providing symptomatic relief of moderate anxiety with depression

# dual-action Triavil®

**containing perphenazine and amitriptyline HCl**

## helps patients get back to business

**Available:**
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

**CONTRAINDICATIONS:** Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

**WARNINGS:** TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

**PRECAUTIONS:** Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

**Perphenazine:** Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

**Amitriptyline:** In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

**ADVERSE REACTIONS:** Similar to those reported with either constituent alone.
**Perphenazine:** Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect, hyperglycemia, endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate, other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

**Amitriptyline:** Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction, arrhythmias; heart block, stroke. *CNS and Neuromuscular:* Confusional states, disturbed concentration; disorientation; delusions; hallucinations; excitement, anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth, blurred vision; disturbance of accommodation; increased intraocular pressure, constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia, eosinophilia, purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting, anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue, headache; weight gain or loss, increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms.* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

**OVERDOSAGE:** All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

*For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.*

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The West Virginia Medical Journal

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# The Small Aortic Root

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*A patient requiring definitive aortic valve replacement six years after commissurotomy for congenital bicuspid aortic stenosis is presented. For anatomic reasons, a valved conduit from the apex of the left ventricle to the ascending aorta was employed. The indications and limitations of this procedure are discussed. The creation of a second outlet for the left ventricle is technically straightforward, and is a viable solution whenever the surgeon encounters a small aortic root.*

For the most part, aortic valve replacement is a routine procedure when standard techniques are employed. This generalization breaks down in the specific situation where the aortic annulus is small or the valve is very heavily calcified and cannot be totally excised without injuring the myocardium or actually perforating the aortic wall or muscle.

The small aortic root has been the nemesis of the cardiac surgeon. When smaller valve replacements become necessary, the effective orifice area decreases out of proportion to the reduction in size. A certain minimum amount of annular apparatus is necessary for fabrication of an artificial heart valve. The opening available for flow is the amount of space remaining after annular requirements have been met. A shrewd choice of artificial heart valve can better a poor situation slightly, but even the best, such as a tilting disk valve (Bjork Shiley) or an equatorical seating ball valve (Smeloff-Cutter), are not well-tolerated in sizes below 21 mm. outside diameter. The operative mortality is still greater in patients requiring the smaller-sized valves, and the clinical status after operation is often marginal. Pressure gradients across these valves are high and could approximate the preoperative condition, thus allowing further progression of left ventricular hypertrophy and strain. This situation does not apply to the mitral valve. The author has replaced the mitral valve successfully in a child under two years of age.

Recently, an old idea has reappeared as a practical solution to this problem: namely, a valved conduit allowing blood to leave the heart from the left ventricular apex and enter the aorta at some convenient location, in essence creating a double-outlet left ventricle. The purpose of this paper is to describe our experience using the conduit in one case of reoperation for congenital aortic stenosis and to discuss the indications for conduits in general.

### Case Discussion

This five-foot, 10-inch, 15-year-old white male was born with congenital aortic stenosis and a bicuspid valve. A harsh crescendo-decrescendo systolic murmur was first noted at five years of age. He remained asymptomatic until the age of nine, when the electrocardiogram indicated progressive hypertrophy of the left ventricle. Cardiac catheterization demonstrated a systolic gradient of 80mm.Hg across the aortic valve. At operation, the aortic valve consisted of two thickened valve leaflets. A commissurotomy was performed. The intraoperative pressure gradient after valvotomy was reduced to 20mm.Hg.

At age 15, he began to notice some dyspnea on exertion, but no syncope. His electrocardiogram showed left ventricular strain pattern

and biphasic T-waves. A grade IV harsh systolic murmur over the base was associated with a palpable thrill. Recatheterization demonstrated a peak systolic gradient of 70mm.Hg; the ejection fraction was 77 per cent; the diastolic wall thickness was 14.8mm., and the myocardial mass was increased to 125 gm./M2. Angiograms showed an eccentric stenotic valve, minimal aortic regurgitation and a small aortic root (Figures 1 and 2).

At operation, the aortic annulus was approximately 12 to 13mm. in diameter. The aorta beyond the root, although somewhat larger, appeared to be substantially under-sized for this tall, 15-year-old boy. Palpation of the aortic root confirmed thickened valve leaflets.

A Norman prosthesis which consists of a short, rigid, valveless pyrolite tube with a Dacron graft extension was inserted into the apex of the left ventricle after coring out a small plug of muscle. The sewing ring of this device was anchored circumferentially to the myocardium using pieces of Dacron felt to distribute the tension of the sutures. The graft end of the conduit was sewn to a second Dacron graft containing a size 23 Bjork Shiley tilting disk valve. The distal end of this addition was then joined end-to-side to the ascending aorta using a partially occluding clamp (Figure 3). Coronary perfusion continued throughout the duration of bypass. Thirty-six hours postoperatively, a hematoma was removed from the left chest.

The remainder of his hospital course was benign with the exception of a persistent fever, which resolved spontaneously in five days. Repeated blood cultures were negative. The temperature elevation was probably due to left lower lobe atelectasis. He was anticoagulated with Coumadin and discharged when the prothrombin time was in the therapeutic range.

The patient was recatheterized four months postoperatively to reassess the hemodynamics (Figures 4 and 5). He was asymptomatic. The postoperative aortic gradient had decreased to 35 mm.Hg, and the total aortic valve area (for both valves) had increased by 33 per cent. This could represent a 33 per cent flow through the conduit and 67 per cent antegrade flow, but auscultation suggested the bulk of egress was now through the prosthesis. The harsh systolic

**Figure 1. The preoperative angiogram indicates a small aortic root, supravalvular narrowing and two eccentrically-placed leaflets.**

**Figure 2. The preoperative angiogram of the aortic root during systole shows the stenotic valve orifice.**

murmur which was heard preoperatively was now almost inaudible. Because the conduit entered the ascending aorta, the calculation of the percentage of cardiac output exiting through the conduit and antegrade across the aortic valve may not be valid.

### Discussion

The use of a conduit between the left ventricle and descending aorta is not a new concept. In 1910, Alexis Carrel[1] used paraffined rubber tubes and jugular veins in dogs. Jeger,[2] in 1923, inserted venous conduits with valves between the left ventricle and the innominate artery in dogs. Sarnoff,[3] in 1955, described a Lucite tube with a Hufnagel valve which was used between the left ventricle and the descending aorta in dogs. He also totally occluded the ascending aorta so that all the cardiac output would exit through the conduit. The dogs survived and were able to perform strenuous activity.

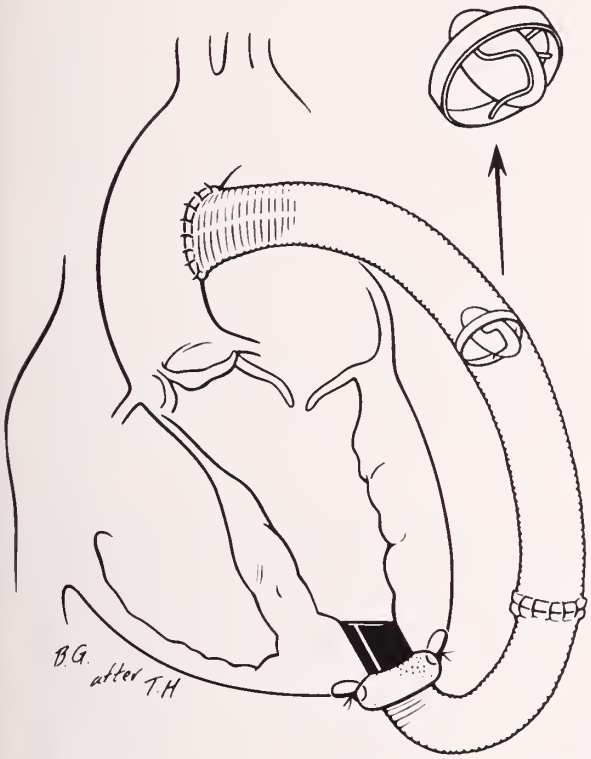


**Figure 3. An artist's rendition of the completed operation. Inset shows the Bjork Shiley tilting disc valve.**

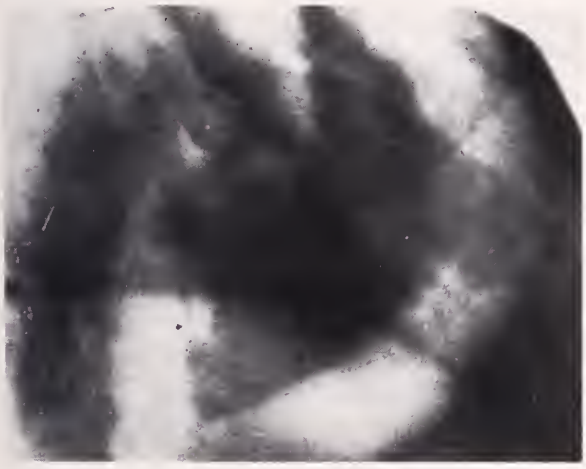

**Figure 4. The postoperative angiogram performed with a transfemoral arteral catheter advanced retrograde into the left ventricle illustrates opacification of the conduit during systolic ejection.**

The technique was applied clinically in 1962 by Templeton,[4] who inserted a rigid methyl methacrylate conduit with a Hufnagel valve into five patients with aortic stenosis, interposing the prosthesis between the left ventricle and the thoracic aorta without the use of cardiopulmonary bypass. One of these patients survived at least 13 years!

Further clinical application of conduits to the left ventricle awaited the development of cardiopulmonary bypass, major advancements in diagnostic radiography, fabrication of synthetic grafts, perfection of rigid apex inlet prosthesis, and availability of prosthetic valves.

The technique was not used again until 1975, when Bernhard[5] inserted a polyurethane-coated

**Figure 5. The postoperative angiogram outlines the conduit and prosthetic valve.**

stainless steel conduit with a porcine valve into a 22-year-old male who had hypoplasia of aortic valve annulus and ascending aorta. In 1975, Cooley[6] fashioned a conduit out of a Dacron graft, and a porcine valve while operating on a patient with a small annulus. He sewed the valve directly to the myocardial surface and connected the graft to the descending aorta. Later, follow-up angiograms demonstrated the anastomosis would occlude during late systole.

### Modifications

Other investigators have proposed various modifications in the basic technique, and have suggested additional indications for valved conduits. Dembitsky *et al.*[7] interposed polyester woven conduits with porcine valves between the left ventricle and infrarenal aorta in two patients with subvalvular stenosis. They suggested that conduits may be an acceptable alternative in patients with idiopathic, hypertrophic, subaortic stenosis.

Pierce *et al.*[8] inserted a Dacron graft with a rigid steel insert and a Hancock valve in a seven-year-old male with subvalvular stenosis who had had two excisions of subvalvular hypertrophy. The aortic valve was partially sutured closed to direct more output through the conduit.

Norman *et al.*[9] observed in their first five patients with a junction to the diaphragmatic aorta that fractioning left ventricular output did not affect visceral function adversely. Further, there was neither myocardial atrophy nor hypertrophy. The postoperative aortic valve gradients were 0-20 mm.Hg. About 40 to 50 per cent of the cardiac output was found to exit via the conduit, and the remainder through the natural valve.

In the updated series of 23 patients with congenital valvular, supravalvular, subvalvular and acquired rheumatic aortic stenosis, many had had one or two previous operations. An early mortality of 13 per cent and a late mortality of nine per cent were better than any other smaller series.[10] Use of valved conduits in patients with heavy, calcified aortic annuli was recommended because the risk of serious complications would otherwise be high. Two patients in this series had saphenous vein bypass grafts to diseased coronary arteries orginating from the valved conduit.

Current preference is interposition between left ventricle and suprarenal aorta so that the segment of conduit containing the porcine valve is in the abdomen.

Norman and Cooley anticipate being able to replace the heterograft valve, should it become necessary, with an abdominal incision without cardiopulmonary bypass.

### 128-Patient Review

Saloman *et al.*,[11] in 1978, reviewed the surgical management of 128 patients with congenital aortic stenosis at Stanford over a 17-year period terminating in 1977. Twenty patients required reoperation and six needed three operations. Of these 20 patients, seven had aortic valve replacements with four early deaths. Fifteen patients had another attempt at valvotomy or subvalvular resection with one death. In the four patients with left ventricle to the descending aorta valved conduits, there were no deaths.

Since 1962, 48 patients with congenital aortic stenosis over the age of one year have received initial surgical treatment at West Virginia University. Of the group, four patients required reoperation and aortic valve replacement. There was one death. The outcome might have been different had the valved conduits been available at that time.

The advantages and disadvantages of valved conduits are still being defined, but a number of statements can be made. The device has been variously terminated in the ascending, descending, suprarenal, and infrarenal aorta. The latter position has the highest potential risk of prosthetic infection should an inflammatory process, such as appendicitis, develop in the abdomen. The suprarenal site is probably well protected by the liver. Connecting the conduit to the ascending or descending aorta should carry the lowest risk of infection.

The flexible Dacron graft may kink at its exit from the ventricle. The authors noted a small kink in this case at the reoperation for bleeding. The situation was improved by a sling of pericardium. Some designers have fabricated conduits with pre-curved rigid or semi-rigid segments.[5, 8, 12] The problem with these precurved ventricular inserts is that they have an abrupt step at the junction of the insert and the Dacron graft, where thrombus may accumulate.

### Valve Types

The conduits contain various types of valves. Porcine valves do not require anticoagulation, but only last 10 years. Replacement then becomes necessary. Even the newer tilting disc artificial valves demand anticoagulation. Some have considered integrating the valve within the

rigid insert; however, this would limit the size of the valve to the size of the insert.[13]

A Dacron graft with a tapered extension could provide room for a larger valve. Valve replacement is simpler when the device is contained in fabric. With the valve contained in fabric some distance from the insert, there is a static column of blood proximal to the valve just prior to onset of systole, very similar to the pooling of blood in a left ventricular wall aneurysm.

However, the contraction characteristics are different. The left ventricular aneurysm retards the efficiency of ventricular contraction, and paradoxical expansion of the aneurysm sac during systole is especially damaging because part of the ventricular volume is lost to systolic ejection. The end result means that a higher wall tension must develop to insure an adequate stroke volume. On the other hand, the conduit occupies less myocardial area, and no paradox exists.

Placement of the rigid insert into the left ventriclar apex causes some element of acute myocardial injury. Most will demonstrate Q waves and ST-T wave changes in inferior limbs of the electrocardiogram. There has been no adverse clinical correlation.

Ultimately, the surgeon must balance the disadvantages of conduits against the potential complications of aortic valve replacement: complete heart block, perforation of aortic wall or septum, paravalvular leak, insufficiency, and high residual pressure gradients.

### Expanded Use Seen

Expanded use would seem to be the future of interposition conduits. Idiopathic, hypertrophic, subaortic stenosis constitutes an as yet untried application. A number of operations have been proposed for this entity including septal myotomy, transaortic resection of hypertrophied septum,[14] transventricular resection of hypertrophied septum,[15] resection of the septum through the right ventricle to permit displacement of the hypertrophied septum,[16] and replacement of the mitral valve with a low profile prosthesis.[17] These operations are often successful and carry a high early mortality. The authors suggest that a valved conduit may be a more appealing alternative.

At the present time there have been fewer than 50 conduits reported in the literature. The vast majority of these patients had had multiple operations and were essentially surgical failures. In this high-risk group, valved conduits were utilized with low early mortality rate. The authors would suggest that the indications should be expanded to include:

1. Small aortic annulus
2. Heavily-calcified aortic valve
3. Reoperation of aortic stenosis
4. Hypoplastic ascending aorta
5. Prosthetic valve malfunctions
6. Idiopathic hypertrophic subaortic stenosis

Select cases of interruption of aortic arch, dissecting aortic aneurysm and aortic insufficiency possibly could benefit from conduit interposition. In the event aortic insufficiency is a significant contributor to preoperative hemodynamic status, the leaflets can be sewn shut, leaving the conduit as the sole exit for blood.

### Conclusion

The experience in this patient indicates that the use of a valved conduit extending from the apex of the left ventricle to the aorta is an acceptable alternative which permits the use of a larger artificial heart valve than a small-sized aortic root could otherwise accommodate. If the aortic stenosis in this patient becomes worse, more and more blood will be shunted to the conduit. Although still in the formative stages, current indications for use of such a left ventricular vent are reviewed and potential problems outlined. The authors have offered additional possible indications for expanded use of the conduit.

### References


1. Carrel A: On the experimental surgery of the thoracic aorta and the heart. *Ann Surg* 52:83, 1910.

2. Jeger, cited by Kuttner H: *Chirurgische Operationslehre*, ed 5, vol 2, Leipzig, Barth, 1923.

3. Sarndoff SJ, Donovan TJ, Case RB: The surgical relief of aortic valvular anastomosis. *Circulation* 11:564-575, 1955.

4. Templeton JY III: Personal Communication.

5. Bernhard WF, Poirer Y, LaFarge CG: Relief of congenital obstruction to left ventricular outflow with a ventricular-aortic prosthesis. *J Thorac Cardiovasc Surg* 19:312, 1975.

6. Cooley DA, Norman JC, Mullins CE, Grance RR: Left ventricle to abdominal aorta conduits for relief of aortic stenosis. *Cardiovasc Dis Bull Texas Heart Inst* 2:376, 1975.

7. Dembitsky WP, Weldon CS: Clinical experience with a valve-bearing conduit to construct a second left ventriclar outflow tract in cases of unresectable intraventricular obstruction. *Ann Surg* 184:317, 1976.

8. Pierce WS, Waldhausen JA, Donachy JH, Whitman V: A new prosthesis for reconstruction of the left ventricular outflow tract. *Ann Thorac Surg* 25:358, 1978.

9. Norman JC, Nihill MR, Cooley DA: Creation of double-outlet left ventricles for left ventricular outflow

obstructions: Initial clinical results in six patients. *Trans Am Soc Artif Intern Organs* 22:332, 1976.

10. Norman JC, Cooley DA: Report of 23 patients using apico-aortic conduits. *Cardiovasc Dis Bull Texas Heart Inst* 4:460, 1978.

11. Solomon NW, Stinson EB, Oyer P, Copeland JG, Shumway NE: Operative treatment of congenital aortic stenosis. *Ann Thorac Surg* 26:452, 1978.

12. Reder RF, Dimich I, Steinfield L, Litwak RS: Left ventricle to aorta valved conduit for relief of diffuse left ventricular outflow tract obstruction. *Am J Card* 39:1068, 1977.

13. Murray GF: Valve placement in the ventricular apex for complicated left ventricular outflow obstruction. *Ann Thorac Surg* 25:368, 1978.

14. Morrow AG, Brockenbrough EC: Surgical treatment of idiopathic hypertrophic stenosis: Technique and hemodynamic results of subaortic ventriculomyotomy. *Ann Surg* 154:181-189, 1961.

15. Baratt-Boyers BG, O'Brien KP: Surgical treatment of idiopathic hypertrophic subaortic stenosis using combined left ventricular-aortic approach in hypertrophic obstruction cardiomyopathy, in Wahtetheim GEW, O'Conner M, London J, Churchill W (eds): 1971, pp 150-159.

16. Kirklin JW, Ellis HF Jr: Surgical relief of subvalvular aortic stenosis. *Circulation* 24:739-742, 1964.

17. Cooley DA, Leachman RD, Wukasch DC: Diffuse muscular subaortic stenosis: Surgical treatment. *AM J Card* 31:1-6, 1973.

18. Brown JW, Dunn JM, Brymer JF, Kirsh MM: Simultaneous treatment of aortic stenosis and coarctation by left thoracotomy with apical aortic conduit. *Ann Thorac Surg* 25:364, 1978.

## Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 ½ by 11 in.) white paper. Wide margins (at least 1 ¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

# Aspirin—Nothing Like It Or Nothing Better

JOHN C. KRANTZ, JR., Ph.D.
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*Although other good analgesics were developed in the 19th Century, Aspirin remains the drug of choice for pain relief and anti-inflammatory activity. Aspirin also is better tolerated.*

WORDS are the building stones of thought. Lewis Carroll, in his timeless book, "Alice in Wonderland," shows how the stones can be chipped out of shape and cause the destruction of the thought.

We are now going through the looking glass with the King and his Messenger:

*The King said, "I feel faint, give me a ham sandwich."*

*He munched it down. "Another sandwich."*

*The Messenger said, "There is nothing left now but hay."*

*"Hay, then," the King murmured in a faint whisper.*

*Alice was glad to see that the hay had revived him a good deal. "There is nothing like eating hay when you feel faint," he remarked as he munched away at the hay.*

*"I should think throwing cold water on you would be better, or giving some smelling salts," Alice suggested.*

*"I didn't say there was nothing better," replied the King; "I said there was nothing like it," to which Alice did not venture a reply.*

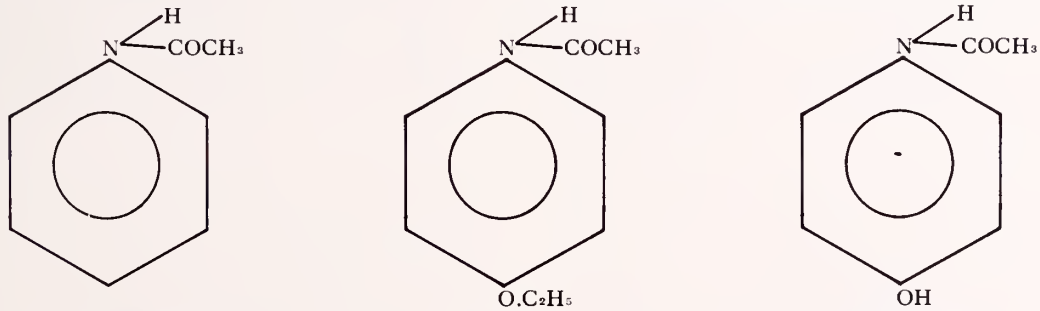
These two expressions of thought, nothing like it or nothing better, can confuse the choice of medication for a patient.

Felix Hoffman, associated with the Bayer Laboratories, was using sodium salicylate to treat his father who was suffering with a rheumatic condition. His father did not tolerate the remedy well and he asked his son, Felix, to bring him some medicine from the laboratory that he might find more helpful. The year was 1899, and lying dormant on the shelf in the Bayer Laboratory was acetylsalicylic acid which had been synthesized about a half century before. The elder Hoffman was treated most satisfactorily with the drug—Aspirin.

Under the direction of two physicians, Dresser and Wohlgemut, the value of aspirin in rheumatic disease was confirmed. Here, the trap, nothing like it or nothing better, was avoided. Sodium salicylate was useful but not well tolerated. Aspirin was like it, but better as it was better tolerated and confers a greater degree of analgesia.

Aspirin essentially is a product of vegetable origin, being derived from salicin, obtained from the bark of the willow tree. Indeed, it was not until the year 1828 that man became independent of the vegetable and animal kingdoms for drugs. In that year, Frederick Woehler synthesized urea from ammonium cyanate. The Rubicon had been crossed. The chemist was now a creator. This experiment was to have tremendous implications for the future of the human race. Medicine was to be in the forefront as the beneficiary of the new, creative laboratories of the organic chemist.

During the latter half of the nineteenth century, the German chemical industry produced great advances in the synthesis of new dyes, ex-




**acetanilid** **phenacetin** **acetaminophen**

**Figure. The relationships of these analgesics to each other are shown in the formulas.**

plosives and drugs. One of the first useful drugs, produced in 1886, was acetanilid. Like aspirin, it evoked analgesia and antipyretic activity. It was followed by phenacetin. Acetanilid was abandoned owing to the production of met- and sulfhemoglobin, and, comparatively recently, phenacetin has diminished in use because of its inducing renal damage upon prolonged use. Finally, the molecule has been modified, as shown in the formula (Figure), to acetominophen.

The competition now appears to lie between aspirin and acetaminophen. The trap is set again—nothing like it or nothing better. Pain and various forms of discomfort are very personal matters, and it would be most unlikely that there would not exist personal preferences for one of the two outstanding analgesics. But let us examine the evidence. If pain involves inflammation, aspirin exerts anti-inflammatory activity and acetominophen does not. So, for the pains, swelling and stiffness of joints in arthritis, aspirin is the drug of choice. Indeed, when one considers our daily consumption of aspirin is between 20 and 30 tons, and that there has not been any marked incidence of side effects, the benefit/risk ratio of aspirin is high. And aspirin springs the "Alice in Wonderland" trap—there is nothing like it and there is nothing better.

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# U. S. Labs Lead World, AMA Finds

LABORATORY medicine as now practiced in the United States is more advanced and of better quality than in any other nation in the world, according to a new book from the American Medical Association.

*Laboratory Tests in Medical Practice*, a 211-page, hard cover volume, is the work of the AMA's Council on Scientific Affairs, in response to allegations of the federal government that laboratory medical tests in the United States had a high degree of error.

The Council named an advisory panel of distinguished physicians to study in detail the laboratory test situation in this nation. The book does not say that all laboratory tests are infallible. The human factor and the technology factor are involved, and sometimes test results are misleading. But this is rare, and seldom leads to problems for the patient because doctors almost never base treatment decisions solely on a single test result.

Richard J. Jones, M. D., head of the AMA's Division of Scientific Activities and Secretary to the Council, declares in the book's preface: "The Department of Health, Education and Welfare (now Department of Health and Human Services) has, in our view, denigrated the excellent quality control now in use (in laboratories), and ignored the medical utilization and relevance of laboratory tests."

The book may be obtained from Order Department, OP-065, American Medical Association, Monroe, Wisconsin 53566.

# The New Medical Practice Act: Implications For Medical Discipline

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*Since July 1, 1980, physicians, podiatrists and physicians' assistants in West Virginia have been under the authority of a Board of Medicine created by the last Legislature. This entity replaced the old Medical Licensing Board, and its duties are more comprehensive than its predecessor's. This article attempts to inform physicians of the intent of the Legislature, and the responsibilities of those who hold licenses to practice the healing arts.*

A milestone in the practice of medicine in this state was passed on July 1, 1980, when the West Virginia Board of Medicine officially came into being through an act of the Legislature. This represented the first major change in the medical practice law since 1931. It has brought West Virginia into the company of those states which are in tune with the times and recognize the intense public interest in matters of health policy.

Prior to the passage of this act, a license to practice medicine in effect conferred a lifetime privilege on an individual. Conviction of a felony was virtually the only grounds for removal of a license. Chapter 30, Article 3, Section 1 of the West Virginia Code now states the new attitude very succinctly:

"The Legislature hereby finds and declares that the practice of medicine and surgery and the practice of podiatry is a privilege and not a natural right of individuals. As a matter of public policy, it is necessary to protect the public interest through enactment of this article and to regulate the granting of such privileges and their use."[1]

There are changes in the make-up of the new Board, and in its duties. Each licensed physician in the state should obtain and read the entire act since it has a direct effect on his livelihood. However, for the purpose of this article, we will concentrate on that portion of the act dealing with professional discipline.

**Professional Discipline of Physicians: The Procedure**

The Board of Medicine is empowered with the right to grant or deny a license to practice medicine and surgery in West Virginia. The Board also may hold disciplinary hearings based on "information received from medical peer review committees, physicians, podiatrists, hospital administrators, professional societies and others." Of particular importance is the new requirement that hospital administrators, professional societies, and insurers *must* report the name of the physician to the Board whenever a disciplinary action is taken. Such instances are included as " . . . hospital privileges have been revoked, restricted, reduced, or terminated for any cause, including resignation . . . ," and "disciplinary action against a member relating to professional ethics, professional incompetence, professional malpractice, moral turpitude or drug or alcohol abuse . . . "[1] This is a significant change. In the past, after losing hospital privileges, a physician could still have an active office practice or move to a new town. Now the Board will know of each disciplinary action and can act further if necessary.

After a hearing, the Board may judge a physician to be unqualified to practice medicine on any of many grounds. Twenty-one examples are listed in the Medical Practice Act and include: obtaining a license by fraudulent misrepresentation; false or deceptive advertising; aiding any unauthorized person to practice medicine; receiving payment for referral of patients; referring a patient to a clinical laboratory in which the physician has a proprietary interest unless disclosing such to the patient; exercising influence within a patient-physician relationship for the purpose of engaging a patient in sexual activity; failing to keep written records justifying the course of treatment of a patient; gross negligence in the use and control of prescription forms;

performing any procedure that would constitute experimentation on human subjects without full, informed, written consent; performing professional responsibilities that the person knows he is not competent to perform; professional incompetence; the inability to practice medicine and surgery with reasonable skill and safety due to physical or mental disability, including deterioration through the aging process or loss of motor skill or abuse of drugs or alcohol.

After receiving notice that there may be grounds for discipline, the Board may investigate further and require a physician to submit to a physical or mental examination. On the basis of its findings, the Board may impose one or more of the following:

1. deny a license to practice medicine and surgery;
2. administer a public or private reprimand;
3. suspend, limit, or restrict the license for not more than five years;
4. revoke a license to practice medicine or prescribe controlled substances;
5. require the physician to submit to care, counseling or treatment as a condition for licensure;
6. require the physician to participate in a program of education;
7. require the physician to practice under the direction of another physician for a specified period of time.

Whichever route is taken, the Board must report its final action to all appropriate state agencies, hospitals, insurance companies, the American Medical Association, professional societies, and the administrators of Medicare and Medicaid.

With such profound ramifications possible, we must take note of the due process safeguards which protect the physician from an erroneous decision. The physician subjected to such a hearing has the following rights: 1) right to written notice listing the reason for the action; 2) right to a hearing heard upon sworn testimony, according to the rules of evidence of trial courts; 3) right to obtain a transcript of all hearings; 4) right to be represented by counsel, introduce evidence, and cross-examine witnesses; 5) right to have his own physician present at the physical or mental examination and make an independent report to the Board; 6) right to judicial review; and 7) right to petition for reinstatement of his license.

It also should be noted that legal immunity from civil or criminal liability is extended to those divulging information to the Board so long as it is without malice and gross negligence. This protects each member of the Board, medical peer review committees, hospital governing boards, insurers, and individuals from legal backlash when they report perceived misdeeds.

Physicians, sad to state, are subject to all the ills of society. Psychiatric disorders, alcoholism, substance abuse, senility, professional incompetence and even overt criminal activity are known to all of us who deal with our peers on a daily basis. The Board of Medicine now has the power to deal with these problems and can even, if needed, coerce impaired physicians into treatment.

**Developing a Program for the Impaired Physician**

The new Medical Practice Act empowers the state medical board to restrict legally the impaired physician. Now the challenge is to develop a program which will restore that physician and return him to practice. In Tennessee, the "staff health and well-being committee" of the hospital replaces the disciplinary aims outlined above with a benevolent, supportive goal. A small committee of senior staff members (none with disciplinary authority) makes a low-key investigation at the request of a colleague, nurse, patient, or the troubled physician's family. An "intervention team" of two or three physicians talks with the troubled physician, emphasizes his strengths, and presents a definite treatment plan. Only when no agreement can be reached is the matter routed through disciplinary channels.[2]

Similarly, in Michigan, the Committee on Impaired Physicians forms small intervention teams on the local level and serves strictly in an advocacy role (to aid the physician). Out of 76 referrals for alcoholism, drug addiction, psychosis, and senility, 52 physicians have been returned to practice. They feel this is a good beginning, but the committee still needs referrals and trained treatment teams.[3]

Numerous other states have developed programs which have proven effective. Oregon, Texas, Georgia, Ohio and Maryland come to mind as states which have good programs and dynamic leadership. Dr. Douglas Talbott of Georgia is quoted as saying that he has returned the equivalent of one medical school class to active practice by his involvement in rehabilitation.[4]

On the national level, the American Medical Association has had three conferences on the disabled physician, and a fourth is scheduled for October, 1980, in Baltimore, Maryland. The Resident Physicians Section of the American Medical Association has produced an excellent monograph, *Beyond Survival*, the thesis of which is that young physicians need to be taught more about living and perhaps a little less about scientific medicine.[5]

West Virginia is just beginning to have the tools to tackle this problem. Our State Medical Association Committee on Impaired Physicians is less than two years old, but its members have been attending conferences and working actively

on legislation. The mid-winter meeting of the State Association last January devoted a half-day session to physician impairment. Our State Medical Association will participate in a regional meeting on the impaired physician in Columbus, Ohio, in March, 1981.

To further aid our colleagues, we need dissemination of information through component societies and hospital medical staffs. Large counties well might set up their own committees on impairment, while smaller societies might find it more feasible to designate a liaison person to contact the state committee on impairment. Interested physicians should attend one of the regional or national meetings which provide "how to" workshops designed to assist them in initiating local programs.

This is a serious problem and must be approached with great caution since any approach to an impaired physician is extremely threatening to that individual. This point is highlighted by the alarming recent report by the Oregon Medical Association in the *Journal of the American Medical Association* asserting a 20-per cent suicide rate in one year among physicians in their rehabilitation programs.[6] Also, personal communication with physicians involved in alcoholic treatment programs indicates that our medical peers have the highest rate of recidivism.

### Prevention

The loss of a colleague through suicide or impairment is tragic and costly. The West Virginia Committee on Impaired Physicians would like to move beyond secondary and tertiary treatment modes into the field of primary prevention. The following are initial steps which might be taken, and which, years from now, might promote physician well-being in West Virginia:

- Provide a free copy of *Beyond Survival* to each sophomore medical student.
- Incorporate lectures on the disabled physician into behavioral medicine courses for medical students.
- Encourage informal evening seminars for private practitioners, faculty, medical students, and spouses to discuss medical education stresses.
- Provide prominent speakers for Medical Grand Rounds to spark interest and enthusiasm.
- Provide current literature for discussion at Residents' Journal Club.
- Offer support groups to interested medical students to discuss the stresses of medical school, transition to clinical years, etc.
- Encourage each medical student and resident to contact his or her personal physician for regular checks and counseling.
- Encourage adequate sleep, physical exercise, and time for reflection and personal growth during the stressful training years.

This is a meager beginning, but by applying our efforts toward primary prevention, perhaps we can reduce the need for legislation mandating disciplinary actions.

### Summary

West Virginia has a new Medical Practice Act which stands as model legislation reflecting cooperation between organized medicine and our State Legislature in a truly altruistic fashion. This law gives us opportunities and challenges to help our colleagues, as well as to protect the public consumers of medical care. The problem of the impaired physician is pervasive in our society, and prevention and early intervention probably will be more effective than attempts to modify established behavior.

### References

1. The Legal Code of West Virginia, Chapter 30, Article 3.

2. Sargent A: Helping Toubled Colleagues. *J Tenn Med Assn* 72(7), 1979.

3. Smith RF *et al.*: Special section on physician impairment. *Mich Med* Sept, 1979.

4. Talbott G, Douglas *et al.*: The MAG disabled doctor's program—a two-year review. *J Med Assn of Ga* 66: Oct, 1977.

5. Tokarz JP, Bremer W, Peter K: *Beyond Survival*, American Medical Association, Published 1979.

6. Crawshaw R *et al.*: An epidemic of suicide among physicians on probation. *JAMA* 243(19): May 16, 1980.

# Medical Grand Rounds

**From the West Virginia University Medical Center**

Edited By
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*Associate Professor of Medicine*

## Recent Advances In Breast Cancer Management

Discussants:
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V. P. SUBRAMANIAN, M. D.
*Assistant Professors of Medicine,*
*Section of Hematology-Oncology*

*Breast cancer is the most common malignancy in women. In recent years, important advances have been achieved in the management of both early, localized breast cancer and in advanced metastatic disease. Post-surgical adjuvant chemotherapy has yielded encouraging preliminary results for patients with early disease. For the many patients with advanced or metastatic disease, the area of endocrine manipulation has shown progress in hormone receptor assays and new effective hormonal agents. These and other recent developments have improved the therapeutic approach for many patients with breast cancer.*

*Doctor Walker:*

Cancer of the breast is the most common malignant disease in women and the leading cause of death due to cancer in the female population. More than 90,000 new patients will be found to have breast cancer in the United States this year. Of these, about 10 per cent will have metastatic disease at the time of diagnosis. The remainder will be treated with some form of local therapy, most frequently mastectomy. However, a large number of patients with limited disease at diagnosis will eventually develop metastatic disease, irrespective of the primary treatment.

In recent years, a number of important advances in breast cancer management have been made. The concept of post-surgical adjuvant chemotherapy is based on sound experimental data from animal tumor models. The application of these principles to women with breast cancer has yielded encouraging preliminary results.

For advanced or metastatic breast cancer, the development of hormonal receptor assays has greatly expanded our knowledge of the hormonal dependence of many malignant lesions. Furthermore, new approaches to hormonal therapy, including the new anti-estrogens, have produced exciting results and suggest that the control of advanced breast cancer will continue to improve.

#### Adjuvant Chemotherapy in Breast Cancer

One of the most disappointing aspects of early breast cancer therapy has been the failure of local measures, either surgery or radiotherapy, to improve survival statistics during the last 20 to 30 years. Regardless of the approach to early breast cancer, at least 50 per cent of women with apparently localized disease at the time of mastectomy will eventually develop metastatic disease.

The reason for the failure of local measures to control breast cancer is now well understood, and relates directly to the concept that at the time of initial clinical detection many patients with breast cancer actually have disseminated disease. Thus, no matter how efficient the local procedures might be at controlling the primary lesion, the subclinical micrometastatic lesions ultimately will progress to advanced or disseminated disease.

The data of the National Breast Project is interesting in this regard, and indicates that the probability of micrometastatic disease at the time of mastectomy is most closely related to the number of regional lymph nodes involved with cancer.[1] Patients with positive axillary nodes at the time of mastectomy have a 66 per cent recurrence rate at five years. Table 1 shows the direct correlation of involved lymph nodes with tumor recurrence.

An important conclusion can be drawn from this prognostic data, and the fact that survival has not been improved by various local procedures in the last three decades. In order to achieve improved survival, the micrometastatic disease left behind after resection of the primary lesions must be approached with systemic therapy. From this concept was born the principle of adjuvant or multi-modal cancer therapy.

### Experimental Tumor Models

The basic principles of adjuvant therapy programs for human malignancy were established from investigation in animal tumor models. These studies demonstrated that malignant lesions grow according to Gompertzian kinetics; that is, tumor cells proliferate rapidly when there is a small tumor burden, but as the lesions increase in size, the growth rate declines sharply.[2] By the time a tumor is first clinically detectable, there are nearly $10^9$ cells present, and the rate of cell proliferation has slowed appreciably.

Several important properties of malignant lesions parallel the growth rate. The potential for metastatic spread is greatest when the rate of proliferation is highest. Thus, it is not surprising that micrometastases frequently are present by the time a tumor is clinically detectable. Similarly, the efficacy of anti-tumor cytotoxic agents is greatest when tumors are small with a rapid cell turn-over rate; the effectiveness of these agents is decreased for larger, more slowly-expanding lesions.

The concept of micrometastatic disease, and the improved efficacy of cytotoxic agents in early disease, were confirmed by adjuvant chemotherapy investigations in animal models. In several different animal tumor models, surgical resection of the primary lesion alone failed to achieve a cure, but surgery plus adjuvant chemotherapy attained a high cure rate.[3] The data for two representative animal tumor model adjuvant therapy experiments are shown in Table 2.

**TABLE 1**

**Effect of Nodal Status on 5-Year Recurrence Rate For Primary Breast Cancer**

| *Nodal Status* | *5-Year Recurrence Rate* |
|---|---|
| Negative Axillary Nodes | 21% |
| Positive Axillary Nodes | 66% |
| 1-3 Positive Nodes | 49% |
| 4 or More Positive Nodes | 81% |

Adapted from Reference 1.

### Early Human Adjuvant Programs

Breast cancer would appear to be the ideal human malignancy in which to test the concept of adjuvant chemotherapy. The data outlined above clearly indicate that micrometastatic lesions frequently are present in patients at the time of initial presentation. Furthermore, a number of effective chemotherapeutic agents have been identified from trials in patients with advanced metastatic breast cancer. One might postulate that these agents would be more effective, and possibly curative, when administered early to patients with micrometastatic disease.

The first well-controlled trial of adjuvant chemotherapy for breast cancer was reported in 1975 by the National Surgical Adjuvant Breast Project (NSABP).[4] In this study, 103 patients with early breast cancer received a two-year course of chemotherapy with a single agent, L-phenylalanine mustard (Alkeran), immediately after mastectomy. The control group of 108 patients received no treatment after mastectomy. The results were quite striking, and showed that at two years after mastectomy the control group had a 22 per cent recurrence rate, whereas the chemotherapy-treated group had only a nine per cent recurrence rate. The initial enthusiasm generated by this study has been tempered by subsequent follow-up reports indicating that only the

**TABLE 2**

**Adjuvant Chemotherapy Experiments in Animal Tumor Models**

| | *Treatment* | *% Cures* |
|---|---|---|
| Lewis Lung Carcinoma | Surgery | 0 |
| | Methyl cyclohexyl chlorethyl nitrosourea (Me CCNU) | 0 |
| | Cyclophosphamide (Cy) | 0 |
| | Surgery + Me-CCNU | 30-40 |
| | Surgery + Cy | 50-90 |
| B16 Melanoma | Surgery | 0-20 |
| | Me-CCNU | 0 |
| | Surgery + Me-CCNU | 70 |

Adapted from Reference 3

premenopausal patients truly benefited from the adjuvant therapy, and that the post-menopausal patients have not shown a reduced recurrence rate.[5]

It is well established that combination chemotherapy with multiple drugs is more effective in controlling advanced breast cancer than single-agent therapy. For this reason, the Italian-NCI group, headed by Bonadonna, initiated an adjuvant chemotherapy program using the widely employed combination of cyclophosphamide (Cytoxan), methotrexate, and 5-fluorouracil.[6] This breast cancer post-surgical adjuvant chemotherapy trial is the most widely quoted and carefully analyzed study reported to date. Bonadonna administered the three-drug combination to 207 patients for a period of one year immediately after mastectomy, and administered no therapy after mastectomy to 179 control patients. The initial results of this study were extremely encouraging, showing a marked reduction in tumor recurrence in the chemotherapy-treated group.

Further analysis of this landmark investigation has been reported almost yearly. It now appears that pre-menopausal patients have benefited significantly, both with regard to delayed tumor recurrence and, more importantly, survival (Table 3). However, the post-menopausal patients, after initially showing a delay in tumor recurrence, eventually have demonstrated an equal recurrence of the malignancy in the treated and untreated groups.[7]

A critical question remains unanswered: why do pre-menopausal patients achieve a favorable outcome with adjuvant chemotherapy, and post-menopausal patients do not? It has been proposed that since chemotherapy disrupts normal ovarian function, the success of adjuvant therapy in pre-menopausal patients is no more than an expensive and toxic medical oophorectomy.

**TABLE 3**

**Italian-NCI CMF Adjuvant Chemotherapy Program: 4-Year Relapse Rate**

| | *Controls (179 Patients)* % | *CMF* (207 Patients)* % | *P Value* |
|---|---|---|---|
| Total Failure | 52.7 | 34.4 | 0.0001 |
| Total Survival | 73.6 | 83.0 | 0.05 |
| Premenopause | 59.2 | 25.0 | 0.00001 |
| Total Survival | 70.6 | 89.6 | 0.02 |
| Postmenopause | 47.6 | 43.8 | 0.25 |
| Total Survival | 75.4 | 76.5 | 0.60 |

Adapted from Reference 7.

*CMF—Cyclophosphamide, Methotrexate, 5 Fluorouracil

However, it has been demonstrated conclusively in a number of studies that surgical oophorectomy is of no benefit in the adjuvant setting.[8]

Other proposed, but unproven, hypotheses to explain the differential response in the two groups relate to the more rapid proliferation rate of breast cancer in pre-menopausal patients, or alternatively, to the frequent dose reductions in older, more drug-sensitive patients. An accurate explanation for the lack of efficacy of adjuvant chemotherapy in post-menopausal patients is of high priority.

### Adjuvant Chemotherapy: The Future

The encouraging results of the NSABP and Italian-NCI investigations have generated enthusiasm for more advanced adjuvant chemotherapy studies in breast cancer. At present, more than 10 multi-center cooperative trials are in progress, employing a number of treatment schedules and combinations.

A five-drug combination adjuvant chemotherapy program recently has been reported by Cooper and Holland.[9] This investigation demonstrates a recurrence rate of only 32 per cent at five years in treated patients, as opposed to a 55 per cent recurrence in untreated patients. And of greater importance, in this study the post-menopausal patients are doing as well as the pre-menopausal group.

More aggressive chemotherapy combinations, including the highly effective agent doxorubicin (Adriamycin), presently are being used in adjuvant programs at a number of institutions. Although the results of many of these studies are preliminary, they suggest that significant advances will be achieved in the near future.

### Adjuvant Chemotherapy: Conclusions

There still are many unanswered questions in the area of post-surgical adjuvant chemotherapy for early breast cancer. However, a number of statements can be made with some confidence from the preliminary results presently available. The concept of adjuvant chemotherapy, initially proven in animal systems, has yielded success in certain subsets of human malignancy. Specifically, pre-menopausal women with operable breast cancer have shown both extended, disease-free interval and improved survival in nearly all adjuvant chemotherapy programs. The results with post-menopausal patients have been less encouraging, but the more recent, intensive chemotherapy programs hold the promise that these patients also will benefit from adjuvant

chemotherapy. For the present, it is imperative that all eligible patients be given the opportunity to participate in adjuvant chemotherapy trials so that these important questions can be resolved.

*Doctor Subramanian*:

**The Treatment of Metastatic Breast Cancer**

When a patient presents with metastatic disease there are several therapeutic options available: (1) hormonal therapy, (2) chemotherapy, (3) combined chemo-hormonal therapy, (4) immunotherapy, and (5) radiation.

*Hormonal Therapy*: Only a minority of patients appear to benefit from hormonal therapy. Good clinical judgement coupled with new laboratory aids are essential for the selection of patients for hormonal therapy.

Clinical criteria that are useful include: (a) If the disease-free interval is less than two years, response to hormonal therapy is poor, (b) Visceral disease such as in the lung, liver, or brain responds poorly to hormonal therapy, but skin, soft tissue and bone involvement respond better, (c) The more rapidly-growing tumors respond poorly to hormonal therapy, (d) Patients who are within five years of menopause do poorly, (e) If prior hormonal therapy has been successful, there is a better chance of response to another hormonal modality, and (f) Patients who have been treated extensively with chemotherapy often do not respond to hormonal therapy.

Despite selection on the basis of these clinical criteria, response rates are only around 30 per cent.

Although several hormone assays[10] have been evaluated, none is able to predict reliably hormonal responsiveness. A high excretion of urinary gonadotrophins has been found to correlate with negative response to estrogen therapy, but this needs further confirmation. Increased excretion of etiocholanolone or androsterone (androgen metabolites) may correlate with response to hormonal therapy.

Estrogen receptors (ER)[11] are cytoplasmic proteins with a high affinity for estrogen molecules. Once bound, these complexes are translocated into the nucleus where they regulate the DNA-mediated messenger RNA synthesis. These proteins first were identified in a mouse uterus, and later were shown to be present in some malignant breast tumors as well.

These receptors are found in about 60 per cent of primary breast cancers, and there is a good correlation between primary and metastatic lesions in the same patient. It is imperative that the tissue from the primary tumor be analyzed for estrogen receptors because, although metastatic lesions have a smiliar incidence of positivity, tissue may be difficult to obtain from metastatic sites.

The question of using estrogen receptors as a diagnostic aid in cases of an unknown primary cancer is sometimes raised. Cases of colon cancer, malignant melanoma, hypernephroma, and others have been shown occasionally to contain estrogen receptors and, hence, one cannot use this test for diagnosis. Further, any time this assay is performed, the tissue should be examined histopathologically for tumor; otherwise, a negative assay could be due simply to absence of tumor.

Patients with positive receptor assays seem to have a better prognosis than those without receptors. This can be explained by the fact that the tumors without receptors often tend to be more undifferentiated. ER positive tumors have been shown to have a high labelling index and growth fraction suggesting a more rapid proliferation.

In patients with positive estrogen receptors, response rate to hormonal therapy is about 57 per cent. On the other hand, patients with negative receptor assays respond in only six per cent of cases. This is irrespective of the nature of endocrine therapy. Since clinical prediction alone will give a response rate of about 30 per cent, there is increased predictability when the assay is used. More importantly, the response to endocrine therapy in ER negative patients is so small that major ablative procedures should be avoided.

**Why Failure to Respond?**

Why do some patients with ER positive breast cancer fail to respond to hormonal therapy? Several explanations have been offered: The response was short-lived and hence not recorded as true response; the tumors are not homogeneous; that is, some cells have receptors and some do not; steps in steroid hormone action beyond initial binding are defective; the tumor may have the ability to metabolize estrogen precursors to active hormone and, thus, create a hormonal milieu adequate for tumor growth in the face of ablative therapy; or the tumor may be dependent on other trophic hormones that can support its growth without estrogen.

Efforts are being made to improve the accuracy of predictions, especially in ER positive cases in which 40 per cent fail to respond to

hormonal therapy. The quantitation of estrogen receptors appears important—the more receptors, the better the response. Progesterone receptors are induced by estrogen-ER interaction. The presence of these receptors indicates that the estrogen receptor complex not only is present but functional; measurement of progesterone receptors may be useful.

Another estrogen inducible substance is the peroxidase enzyme activity. This has been found to correlate well with response. Finally, an *in vitro* assay with tumor cells for endocrine responsiveness is being developed.

### Types of Hormonal Therapy

Of the three surgical hormonal therapy procedures that are available, oophorectomy is done only in pre-menopausal patients with metastatic breast cancer. Adrenalectomy and hypophysectomy are reserved for patients who did not respond to oophorectomy, or post-menopausal patients. The decision whether to do adrenalectomy or hypophysectomy is based primarily on personal preference and availability of surgeons.

Estrogens are first-line treatment in patients more than five years post-menopausal. Those under five years often are refractory to any form of hormonal therapy.

Anti-estrogens are synthetic compounds which inhibit estrogen action by competitive binding. Chief among them is tamoxifen (Nolvadex®) — a triphenylethylene estrogen antagonist.[12] This is found to be at least as effective as estrogens and androgens in post-menopausal patients. Patients who are less than five years into menopause tend to respond poorly. Twenty-five to 60 per cent of patients respond with seven to 18 per cent complete remission. Patients with positive estrogen receptors respond more often.

Side effects are uncommon, but include nausea, vomiting, hot flashes, headaches, dizziness, mental confusion, transient thrombocytopenia, leukopenia and decreased hemoglobin. Pulmonary embolism and thrombophlebitis have been reported. Fluid retention also may occur.

An interesting phenomenon called tumor flare[13] has been reported with tamoxifen therapy. This usually occurs after two to three weeks of therapy. It is seen as increased size of soft tissue lesions with or without erythema, and/or increasing bone pain and worsening bone scan sometimes associated with hypercalcemia. This more often is seen in patients with positive estrogen receptors. Many of these patients subsequently show an objective response. Thus it is important to warn patients of this possibility and not to discontinue therapy.

The role of tamoxifen in post-menopausal patients is not defined. Although it may be tried as the first hormonal therapy it is more expensive than estrogen.

Use of tamoxifen in pre-menopausal patients has not been well studied. Available results suggest it is effective. It alters menstrual periods and can cause vaginal bleeding.

Aminoglutethimide initially was used as an anti-epileptic compound, but was found to cause adrenal suppression. It blocks the conversion of cholesterol to pregnenolone, an early step in steroid synthesis. Since this block can be overcome by an increase in ACTH production, it is necessary to block this by concomitant administration of dexamethasone or hydrocortisone. Besides interfering with steroid synthesis, this drug has been shown to decrease peripheral aromatization as well. Clinically, this drug is comparable to adrenalectomy in terms of effectiveness. In fact, use of this drug often is referred to as medical adrenalectomy, though this is reversible.

A high degree of compliance is necessary for its use in therapy of breast cancer. Side effects also are numerous and include skin rash, drowsiness, lethargy, dizziness and ataxia. The role of aminoglutethimide is not yet defined, but it might be used instead of surgical adrenalectomy.

### Prolactin Role Unclear

Prolactin has been postulated to play a role in breast cancer development, but this is not entirely clear. However, L-DOPA, as a prolactin inhibitor has been found to be useful in predicting hormonal responsiveness in patients with bony metastases and bone pain. Minton and coworkers use 250 to 500 mg. of L-DOPA every four hours for 48 to 96 hours.[15] A positive test consists of relief of bone pain and correlates with response to hormone. Other prolactin inhibitors are bromo-ergocryptine and lergotrile mesylate. Both currently are under investigation.

*Chemotherapy*: Compounds demonstrating activity against metastatic breast carcinoma include adriamycin, cyclophosphamide, 5-FU, methotrexate, vincristine and mitomycin. However, responses to these single agents are short-lived, and no significant prolongation of life has been noted.

In 1969, Cooper[18] reported about 90 per cent response rate by using a combination of five

drugs (cyclophosphamide, methotrexate, vincristine, 5-FU and prednisone). Although subsequent reports were less spectacular than this, combination chemotherapy is far superior to single agents in terms of response rate, median duration of remission and survival.[16]

### Other Therapeutic Modalities

*Chemohormonal Therapy*: The combination of two individually-successful modalities to improve therapy further has been attempted. A study from Mayo Clinic[17] compared oophorectomy and immediate chemotherapy with oophorectomy with chemotherapy at relapse and found combined therapy to be superior.

On the other hand, there are speculations that hormonal therapy might make the tumor less proliferative and hence retard the effectiveness of chemotherapy. At present. several cooperative groups are evaluating the potential of combined chemohormonal therapy.

*Immunotherapy*: Although many innovative approaches are being tried in the field of immunotherapy and hold considerable promise for the future, it still is too early to apply them in routine clinical practice. Nonspecific and specific immune stimulation and passive transfer of immunity are being evaluated.

*Radiation Therapy*: Radiation therapy is useful in controlling local recurrences in the chest wall, as palliative treatment in patients with severe bone pain, to prevent pathologic fractures in weight-bearing bone, in management of spinal cord compression and control of brain metastases.

### Supportive Care

Management of metastatic breast cancer also involves meticulous attention to pain, nutrition and emotional support, especially during periods of depression which patients commonly experience. Metastatic breast cancer in many patients is a chronic disease, requiring years of follow-up.

### References


1. Fisher B, Slack NH, Bross IDJ, Cooperating Investigators: Cancer of the breast: Size of neoplasm and prognosis. *Cancer* 24:1071-1080, 1969.

2. Skipper HE: Kinetics of mammary tumor cell growth and implications for therapy. *Cancer* 28:1479-1499, 1971.

3. Schabel FM Jr: Rationale for adjuvant chemotherapy. *Cancer* 39:2875-2882, 1977.

4. Fisher B, Carbone P, Economou SG *et al.*: L-phenylalanine mustard (L-PAM) in the management of primary breast cancer. *N Engl J Med* 292:117-122, 1975.

5. Fisher B, Glass A, Redmond C *et al.*: L-phenylalanine mustard (L-PAM) in the management of primary breast cancer. *Cancer* 39 (suppl): 2883-2901, 1977.

6. Bonadonna G, Brusamolino E, Valagussa P *et al.*: Combination chemotherapy as an adjuvant treatment in operable breast cancer. *N Engl J Med* 294:405-410, 1976.

7. Bonadonna G, Rossi A, Valagussa P *et al.*: The CMF program for operable breast cancer with positive axillary nodes. *Cancer* 39 (suppl): 2904-2915, 1977.

8. Ravdin RG, Lewison EF, Slack NH *et al.*: Results of a clinical trial concerning the worth of prophylactic oophorectomy for breast carcinoma. *Surg Gynecol Obstet* 131:1055-1064, 1970.

9. Cooper RG, Holland JF, Glidewell O: Adjuvant chemotherapy of breast cancer. *Cancer* 44:793-798, 1979.

10. Bulbrook RD: Prediction of response of breast cancer to treatment, in Holland JF, Frei E (eds): *Cancer Medicine,* Philadelphia, Lea and Febiger, pp 907-911, 1973.

11. Lippman ME, Allegra JC: Receptors in breast cancer. *N Engl J Med* 299:930-933, 1978.

12. Heel RC, Brogden RN, Speight TM, Avery GS: Tamoxifen: A review. *Drugs* 16:1-24, 1978.

13. Plotkin D, Lechner JJ, Jung WE, Rosen PJ: Tamoxifen flare in advanced breast cancer. *JAMA* 240: 2644-2646, 1978.

14. Lipton A, Santon RJ: Medical adrenalectomy using aminoglutethimide and dexamethasone in advanced breast carcinoma. *Cancer* 33:503-512, 1974.

15. Minton JP, Dickey PR: Levodopa test to predict response of carcinoma to surgical ablation of endocrine glands. *Surg Gynecol Obstet* 136:971-974, 1973.

16. Young RC, Lippman M, DeVita VT *et al.*: Perspectives in the treatment of breast cancer. *Ann Int Med* 86:784-798, 1977.

17. Ahmann DL, O'Connell MJ, Hahn RG *et al.*: Evaluation of early or delayed adjuvant chemotherapy in premenopausal patients undergoing oophorectomy. *N Engl J Med* 297:356-360, 1977.

18. Cooper RG: Combination chemotherapy in hormone resistant breast cancer. *Proc Am Assoc Cancer Res, Am Soc Clin Oncol* 10:15, 1969.

*A message from . . .*

*The President*

## THE OLD GUARD CHANGETH

THE old guard changeth. The replacement will not be the pensive pen of the Immediate Past President, *Ward*ing off the attacks with words in the Hesperidian phrases of his predecessor, but deeply cutting remarks *Fix*ing the mind on its essential goals. May my year be as fruitful as that which has gone before.

Never has this Association faced the challenges, the opportunities, the responsibilities that confront us this year. We, you the membership, the House, the Council and the Executive Committee, must decide whether to construct "our own house," develop our "own insurance," and increase our dues.

Some of these decisions will have been made, or partly made, by the time you read this message. These items are within the organization. Greater yet are the needs to provide good, conscientious, cost-effective, sincere, warm care to our patients in the best manner our ever increasing medical knowledge can provide.

This provision must be free from the stress of government bureaucracy (spelled with a "burr") and licentious legality (spelled with a "lie").

The battle is on. I promise to bend every effort in a sincere fight to accomplish those tasks which prudence and guidance from a fine team will permit.

My hope is that, a year from now, I can look back and—with the help of the membership and our many friends within and outside the profession, and the guiding hand of the almighty God—feel some battles have been won.

L. Walter Fix M.D.

L. Walter Fix, M. D., *President*

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

**A VITAL PROGRAM**

Perhaps lost, or at least overlooked by many, in *The Journal's* convention issue in August was an annual report by the State Medical Association's Committee on Medical Education and Hospitals. Some editorial comment was justified at the same time the report appeared, but space limitations interfered. We'll ask your acceptance of that comment now, because of the highly significant work that report outlined.

The Committee's 1979-80 activity largely has been centered in one of the Medical Association's most significant assignments—that of serving as an arm of the American Medical Association in accrediting continuing medical education (CME) programs offered by community hospitals and several specialty organizations.

As the report indicated, the Association and the Medical Education Committee have been at this task since early 1973. They got into this demanding but very satisfactory work because, at that time, there was no other institution or group in the state providing such accreditation.

The historical record is impressive. Twelve hospitals and four specialty groups have been surveyed since May of 1973—and including resurveys, 41 site visits, with 27 individual physicians as team members, have been conducted. For the past two years, R. James Yates, M. D., of Beckley has served as the Committee Chairman and headed the accreditation program, along with other Committee work.

The Association and the Committee determined, from the very beginning, that the accreditation undertaking would be no rubber-stamp effort. That goal has been pursued strictly, and fairly. If a hospital's CME program fails to measure up to established CME criteria and standards, it is judged accordingly.

In at least one instance, initial accreditation of even a provisional nature has been denied. In that case, the hospital added some staff, restructured its program from the ground up, and was approved on a second survey. In several other instances, provisional accreditation has been accompanied by clear directives for strengthening education programs — and further approval has been contingent upon evidence that such steps have been taken.

Members of the Medical Education Committee have devoted significant amounts of time and effort—particularly in carrying out original and re-survey site visits—to make the accreditation program a success. And the Association knows it's a success because it has been possible, at various meetings, to compare it with those elsewhere.

The benefits, to the public as well as the medical profession, are of vital importance. For the public, CME is a critical part of Medicine's ever-growing efforts to improve physician skills, and ensure the highest possible quality of care. For the physician, the program means opportunities to obtain accredited instruction and courses "close home," with savings both of a financial nature and in time he can devote to patient care.

At this writing, other community hospitals have made at least preliminary inquiries regarding the accreditation procedure, and what is required in the way of numbers and quality of programs—as well as the staff structure necessary for ongoing program review.

We would encourage those hospital medical staffs, and others, to join the parade. The demands of the times, in such areas as quality assurance and risk management as they relate to professional liability, require strong, viable CME offerings constantly adapted and readapted to the practice and needs of physicians.

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**WINNING THE WAR**

Since July 1, West Virginia's physicians have been working under provisions of a new Medical Practice Act. We respectfully call to your attention a special article prepared by Drs. William N. Walker of Clarksburg and Patricia W. Williams of Morgantown which appears in this issue of *The Journal*, and details the practical impact of key parts of the legislation. In the news section is further material dealing with the practice act.

As has been indicated previously — and is again emphasized—the State Medical Association-developed bill enacted by the 1980 Legislature represents the first complete rewrite of the practice act in 99 years, and the greatest single modernization since 1931. While some additional work might lie ahead to smooth a few rough edges in the new statute, there remains every reason to believe that hopes for a much more effective, fair and manageable law have been realized.

It's also true, however, that success in obtaining enactment of such legislation is just the first step toward overall accomplishment of the objectives represented. In terms of warfare, the legislation represents victory in a battle. The war, itself, in the form of effective application of the act, still must be won.

At this writing, the West Virginia Board of Medicine (successor to the old Medical Licensing Board of West Virginia) is at work developing administrative rules and regulations which will be critical to the practical implementation process. No one but the Board can do this.

In other words, the Board of Medicine must implement the law and see that its provisions are properly applied. This is not an easy assignment, but it must be done well, and with reasonable dispatch. We have confidence that the Board will meet the challenge.

It perhaps also is appropriate to reflect a bit further here on another significant 1980 legislative enactment — the so-called "peer review bill." Once again, this legislation, explained in the news section of *The Journal* in May, represents a victory in battle. This time, the war must be won out in the communities, and particularly within the theater of operations embracing hospital medical staffs.

The new act protects records, discussions and the like of peer review, audit and other committees from discovery, by subpoena or otherwise: and from admission into evidence in any civil action which might arise out of matters subject to review. Medical and hospital associations have stressed that such protection is imperative if committees are to operate in an effective manner. The 1980 legislative success came after six years of effort.

Of particular significance, also, is the close relationship of the practice act and the immunity statute with numerous other programs and activities now centering about quality of care: and the direct connection between such legislation and the overall professional liability picture.

In the face of another threatened crisis of major proportions in the frequency and severity of malpractice claims, such tools as a strong medical practice act, and legislation giving medical audit, quality assurance and other committees the freedom necessary for solid, on-going review of practice patterns are critical.

## Our Readers Speak

### Commends Message, Editorial

(*Addressed to Dr. Stephen D. Ward, Wheeling, then President, West Virginia State Medical Association.*)

I appreciated and enjoyed your message in the June, 1980, *Journal*. I think yours is a reasonable, informative approach to the problems the state is experiencing with Medicaid. I also particularly appreciated your encouragement to physicians to continue the tradition of providing care to those in need without regard to the ability to pay. I tend to avoid making such suggestions to physicians who, by and large, provide such help. I don't blame them for not enjoying the preaching of others, particularly when other professions are not so frequently told that they ought to provide their services without being paid or with occasionally lower than usual payments.

The editorial which followed your message is also quite reasonable. It certainly reflects the state of affairs.

I don't have any quarrel with the five suggestions you make for improving the situation.

As you may know, we are instituting co-payments for pharmacy service. (*Editor's Note*: This was temporarily delayed by a court order in July.) The federal regulations prohibit our using co-payments, however, for mandatory services such as physician fees. It is also interesting to note that we are limited in the amount of the co-payment. Federal regulations do not allow a co-payment of more than $.50 for prescriptions under $11 or a co-payment of more than $1 for prescriptions that are more expensive. My original plan was to have the co-payment of $1 for all prescriptions, but that is prohibited. The pharmacists, who will collect more money through the co-payment, are, in some cases, complaining about the $.50-$1 differential. They say it is quite difficult to look up the prices for each patient in a timely fashion.

I certainly have no quarrel with family members providing more toward the care of their relatives in nursing homes.

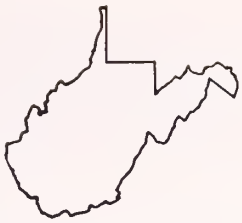
To the end of eliminating abuse and fraud, we have established a rather vigorous Medicaid Fraud Unit. However, securing indictments or prosecution against clients or providers of welfare services is very difficult. Everyone speaks about it, but few really want to do anything about it. Fortunately, we have the fourth lowest error rate in the country in Medicaid, which means that there is almost no fraud. And I hope the MMIS will identify patients who are over-using medical resources.

We are working on your last two suggestions, too, both with the Legislature and with the executive branch.

I have given your editorials wide circulation in the past, and I will do so with these messages as well . . .

Leon H. Ginsberg
Commissioner
West Virginia Department of Welfare

# GENERAL NEWS



## Gastroenterologist, Surgeon On Mid-Winter Program

A Morgantown gastroenterologist and a Charleston surgeon will be among the speakers for the 14th Mid-Winter Clinical Conference to be held in Charleston next January 23-25.

James W. Manier, M. D.

M. M. Boustany, M. D.

The annual continuing medical education event is sponsored by the State Medical Association and the Marshall University and West Virginia University Schools of Medicine.

Dr. James W. Manier, who was named in July as Professor of Medicine and Chief of the Section of Gastroenterology at the WVU School of Medicine, will speak on colonoscopy during conference talks on fiberoptics, the Program Committee announced.

It also was announced that Dr. Mohammed M. Boustany of Charleston will discuss the surgical treatment (stapling) of obesity.

The Program Committee, again headed by Drs. Joseph T. Skaggs and Ralph H. Nestmann, both of Charleston, will be providing more details as to specific subjects and speakers in upcoming issues of *The Journal.*

The program planned to date also includes the subjects of microsurgery, allergies, drug interactions, antibiotic update, controversies in medicine, individual practice association (IPA) health maintenance organizations (HMOs), and state health concerns.

The conference will begin Friday afternoon, January 23, with talks on fiberoptics and microsurgery, followed that evening by a physician's session presented by the West Virginia Medical Institute, Inc., and a concurrent public session on allergies.

The presentations on drug interactions and antibiotic update are scheduled Saturday morning. The speaker for the Friday night public session also will present a paper on allergies for physicians Saturday morning.

### Controversies in Medicine

Controversies in medicine will constitute the Saturday afternoon session. In a discussion of the treatment of obesity, two speakers will take the behavioral modification approach and the surgical treatment approach (Doctor Boustany).

In a discussion of "TIA: Is Surgery Indicated?," two speakers will take "pro" and "con" positions.

The presentation on state health concerns and a panel on HMOs are scheduled for the concluding Sunday morning session.

Doctor Manier came to WVU from Marshville, Wisconsin, where he was a clinical gastroenterologist and Associate Director of the University of Wisconsin's internal medicine residency program at Marshville Clinic.

He also has served on the faculties of the University of Minnesota and the University of Iowa.

A graduate of Vanderbilt University, Doctor Manier received his residency training in internal medicine at Baltimore City Hospital and the University of Wisconsin, and took further postgraduate study in gastroenterology at the University of Pennsylvania, the University of California at Los Angeles, the Mayo Clinic and the Royal Free Hospital of London, England.

He is a Diplomate of both the American Board of Internal Medicine and the American Board of Gastroenterology, and has held office in a number of state, regional and national professional organizations.

**Research Interests**

His current research interests are the clinical evaluation of the new, flexible sigmoidoscope and the diagnosis and epidemiology of viral hepatitis. He is the author of approximately 30 publications in gastroenterology and general medical journals.

Doctor Boustany is Clinical Assistant Professor of Surgery, WVU Charleston Division, and a Fellow of the American College of Surgeons. His major clinical interests are in morbid obesity, gastrointestinal surgery and endoscopy, and surgical nutrition.

He is a member of the staffs of Charleston Area Medical Center (CAMC) and St. Francis Hospital in Charleston, and Herbert J. Thomas Memorial Hospital in South Charleston.

A native of Hama, Syria, he received his M. D. degree in 1970 from the Medical School of Damascus University in Damascus, Syria. He interned at Hutzel Hospital in Detroit, and completed residencies at Pontiac (Michigan) Hospital and CAMC.

Also serving on the Program Committee are Drs. William O. McMillan, Jr., Charleston; Maurice A. Mufson, Huntington, Robert L. Smith, Morgantown, and C. Carl Tully, South Charleston.

The Committee also is receiving assistance from WVU Charleston Division staff members J. Zeb. Wright, Ph. D., Coordinator of Continuing Education, Department of Community Medicine, and Sharon A. Hall, Conference Coordinator.

# *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*General Ophthalmology*, by Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 410 pages. Price $15. Lange Medical Publications, Los Altos, California 94022. 1980.

*Current Pediatric Diagnosis and Treatment, 6th Edition*, by C. Henry Kempe, M. D.; Henry K. Silver, M. D.; and Donough O'Brien, M. D. 1122 pages. Price $20. Lange Medical Publications, Los Altos, California 94022. 1980.

*The Chemistry of Human Behavior*, by Herbert L. Meltzer, Ph.D. 261 pages. Price $17.95. Nelson-Hall Publishers, 325 W. Jackson Boulevard, Chicago, Illinois 60606. 1979.

*Basic Histology, 3rd Edition*, by Luis C. Junqueira, M. D.; and Jose Carneiro, M. D. 504 pages. Price $15.50. Lange Medical Publications, Los Altos, California 94022. 1980.

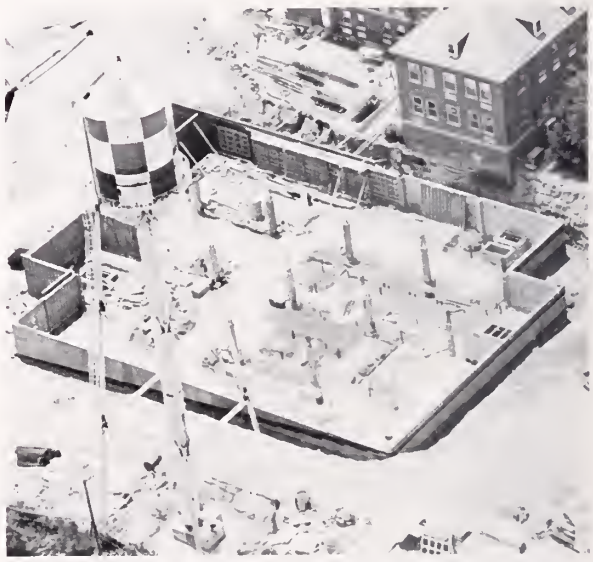
## Family Practice Conference September 25-26

Subjects ranging from athletic injuries to malpractice liability in obstetrics will be discussed during the Sixth Annual Hal Wanger Family Practice Conference to be held September 25-26 in Morgantown.

The West Virginia University Medical Center Auditorium in Morgantown will be the site.

A conference highlight will be a talk on the Three Mile Island nuclear power plant by the Pennsylvania State Health Director.

Sponsors are the WVU School of Medicine's Department of Family Practice and Office of Continuing Medical Education, and the West Virginia Chapter, American Academy of Family Physicians (AAFP).



**The outline of the new Basic Sciences/Medical Education Building of the Marshall University School of Medicine is starting to take shape at the Huntington Veterans Administration Medical Center. The $9.2 million project is targeted for completion in mid-1981. Financed by the Veterans Administration, it will contain all of the medical school's basic sciences classrooms and offices, approximately one-third of the school's clinical departments, and various support services. The three-story structure will contain approximately 75,680 square feet.**

The program meets the criteria for 11 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association; is acceptable for 11 prescribed hours by the AAFP. and is approved for 1.1 WVU Continuing Education Units.

The speakers (WVU faculty unless otherwise noted) and topics for the Thursday, September 25, session will include "Injuries to the Immature Athlete"—Eric Jones, M. D., Assistant Professor. Department of Orthopedics; "Developmental Screening in Pediatrics"—Paul Dworkin, M. D., Assistant Professor, Department of Pediatrics; "Dental Emergencies in Medical Practice," David Puderbaugh, D. D. S., Associate Professor, School of Dentistry;

"The Easy Approach to Acid-Base Balance"—Terry Heironimus, M. D., Professor, Department of Anesthesia; "Potential Radiation Health Hazard at Three Mile Island"—H. Arnold Mueller, M. D., State Health Director, Commonwealth of Pennsylvania; "Common Ocular Problems"—V. J. Raju, M. D., Assistant Professor, Department of Ophthalmology;

"Total Knee Replacement"—David Blaha, M. D., Assistant Professor, Department of Orthopedics, and "Evaluating the Child with the Surgical Abdomen"—Ellen Hrabovsky, M. D., Associate Professor, Departments of Surgery and Pediatrics.

Speaking on Friday will be John Wurtzbacher, M. D., Assistant Professor, Department of Cardiology, "Current Concepts in Managing Congestive Heart Failure;" Barbara Farrell, M. D., Fellow, Department of Neurology, "Evaluating the Comatose Patient;"

Cedric Quick, M. D., Professor, Department of Otolaryngology, "Hey Doc, It's My Sinus," and Kevin Farrell, M. D., Assistant Professor, Departments of Surgery and Anesthesia, "Evaluation of Multiple-Trauma Patient."

"Doctor, What Is Your Liability Quotient?," a 1:30 P. M. symposium exploring malpractice liability in obstetrics, will conclude the conference. Symposium participants will be Thomas Auman of Charleston, Account Supervisor for Aetna Life and Casualty (the State Medical Association's carrier for malpractice insurance); John F. Foss, M. D., WVU Associate Professor, Department of Obstetrics and Gynecology; Elba Gillenwater, Jr., J. D., Wheeling attorney, and Ronald J. Weisser, Jr., M. D., WVU Associate Professor, Department of Family Practice.

## Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb. Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal).

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

| | | |
|---|---|---|
| Sept. 5-6 | Morgantown | Urology Reunion Days |
| Sept. 18-19 | Charleston | Spirometry for Occupational Health |
| Sept. 25-26 | Morgantown | 6th Annual Hal Wanger Family Practice Conference |
| Oct. 2 | Morgantown | Annual Pediatric Teaching Day |
| Oct. 3-4 | Morgantown | W. Va. Chapter, American College of Surgeons |
| Oct. 11-13 | Charleston | Biomechanics in the Practice of Orthopedic Surgery |
| Oct. 17 | Morgantown | Nutrition and Metabolism Seminar |
| Oct. 21-22 | Charleston | Nutrition: The Childbearing Years |
| Nov. 21-22 | Morgantown | 1st Annual Sports Medicine Symposium |

## Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

*Cabin Creek* (2nd Wed., 8-10 A. M.)

*Welch, Stevens Clinic Hospital*
(3rd Wed., 11 A. M.-1 P. M.)

October 15

| | |
|---|---|
| Office Pediatrics | Herbert H. Pomerance, M.D. |

*Buckhannon, Upshur-Buckhannon Middle School*
(3rd Thurs., 7-9 P. M.)

September 18

| | |
|---|---|
| Infectious Diseases | Patrick Robinson, M. D. |

October 16

| | |
|---|---|
| Medico-Legal Aspects of Health Delivery | Richard D. Lindsay, M. D., J. D. |

*Oak Hill, White Oak Country Club*
(4th Tues., 7-9 P.M.)

September 23

| | |
|---|---|
| Commonly Prescribed Procedures in Emergency Medicine | Jack R. Page, M. D. |

*Whitesville, Raleigh-Boone Medical Center*
(4th Wed., 11 A. M.-1 P. M.)

September 24

| | |
|---|---|
| Dermatology: Recognizing Skin Diseases | Robert B. Point, M. D. |

*Williamson, Appalachian Power Company Auditorium* (1st Tuesday, 6-8 P. M.)

## World-Wide Family Practice Conclave In October

For the first time, the world's two major family practice groups will stage their scientific assemblies in a joint conference October 4-9. This joint meeting will be held at the Rivergate Exhibition Center in New Orleans.

The two groups are the American Academy of Family Physicians (AAFP) and the World Organization of National Colleges, Academies and Academic Association of General Practitioners/Family Physicians (WONCA).

More than 7,000 family physicians from 40 countries are expected to participate in the 1980 Annual AAFP Scientific Assembly and Convention/WONCA Ninth World Conference. More than 2,000 of these physicians will be from foreign nations. Total registration is expected to reach 10,000.

"A World of Caring" is the theme for this joint international continuing medical education forum.

An advocate of continuing medical education, the AAFP requires its members to earn 150 hours of approved continuing medical education every three years. Family physicians can accrue more than 30 of these hours by participating in the various AAFP/WONCA joint conference educational modalities.

The AAFP Scientific Assembly will offer the following scientific activities that will cover more than 100 practical subjects: 30 clinical seminars, 28 continuing education courses, four symposia on "Practical Diagnosis of the Cardiac Patient," 14 live teaching demonstrations, 10 taping and strapping demonstrations, 14 dialogue sessions, 10 programmed instruction courses on "Teaching Machines," fracture demonstrations, approximately 60 scientific exhibits and 300 technical exhibits, and 17 lectures by internationally-renowned speakers.

In addition to the above, the WONCA Conference also will provide plenary sessions, committee forums and free-standing papers.

The Congress of Delegates, governing body of the 48,000-member AAFP, will convene at 8:00 A.M., Saturday, October 4, in the New Orleans Hilton and close approximately Monday noon, October 6, after election of officers. Dr. Joseph A. Smith of Dunbar is the West Virginia Chapter, AAFP, Delegate, with Dr. Richard E. Flood of Weirton as Alternate Delegate.

Some 900 family physicians will receive the degree of Fellow-AAFP Tuesday, October 7, in the Marriott Hotel. Following the ceremony, the new officers of the AAFP Board of Directors will be inaugurated. Dr. Sam A. Nixon, Houston, Texas, will be installed AAFP President.

The AAFP Presidents' Reception, scheduled for October 8 at the New Orleans Hilton, will honor retiring President and Mrs. John S. Derryberry, Shelbyville, Tennessee, and incoming President and Mrs. Nixon.

The New Orleans Hilton will be the AAFP Scientific Assembly headquarters hotel, and the Marriott will be headquarters for the WONCA Ninth World Conference.

## State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected from January 1 through June 30, 1980:

**Boone**

Sriramloo Kesari — Madison

**Cabell**

N. G. Baranetsky — Huntington
Anthony J. Bowdler — "
Richard O. Buscho — "
David Charles — "
Lewis Clayman — "
Omar A. El-Bash — "
Earl J. Foster — "
Jithendra N. Goonewardena — "
John A. Hunt — "
Donald W. Peterson — Beckley
Howard Quittner — Huntington
Francisco Rivas — "
Henry P. Staub — "

**Central West Virginia**

Frank A. Scattaregia — Weston
Stephen Michael Smith — Buckhannon

**Eastern Panhandle**

R. J. Estigoy — Martinsburg
F. H. Ross, Jr. — "

**Fayette**

Pedro L. Casingal — Oak Hill
Ghassan Y. Dagher — Montgomery

**Greenbrier Valley**

James W. Banks — Ronceverte
Anthony Dougherty — "
Francis Henry — "
James Pfeiff — "
C. D. Tamea — "

**Hancock**

Patrick H. Macedonia — Steubenville, Ohio

**Harrison**

Arun Acharekar — Clarksburg
Halberto Cruz — Bridgeport
Katherine A. Hoover — Glenville
Sidney Jackson — Bridgeport
Joseph Kassis — Clarksburg
James LeVos — Pennsboro
Ali Rahimian — Clarksburg

**Kanawha**

James L. Bergman — Charleston
Jerry W. Edens — Elkview
Joseph Ivan Golden — Dawes
Thomas Woodrow Graber — Charleston
Charles W. Guise — Evans
Hatem Hossino — Charleston
Arundhati V. Kshirsagar — Dunbar
Sidney C. Lerfald — Charleston
Cyrus Mali — "
Thomas Ray Neis — South Charleston
Dionisio Policarpio — Charleston
Gina M. Puzzuoli — "
Humayun Rashid — "
Richard George Rowe — South Charleston
Loreto S. Santiago — Grafton
Edmund C. Settle, Jr. — Charleston
Robert Torance Westmoreland — "

**Logan**

Enayat O. Ataii — Logan
R. M. Bellam — Man
Alberto A. Fernandez — Harts
Harry D. Fortner — Logan
Esmaralda Gambetta-Hampton — Glenside, Pa.
Yasa J. M. Reddy — Man
S. N. Subramaniani — Logan
Maria Luna Y. Tan — "

**Marion**

P. Kent Thrush — Fairmont

**McDowell**

John Robert Greene III — Algoma

**Mercer**

Yong-Kwon Chun — Bluefield
Naeem A Qazi — "
William Frederick Ruppel — Bastian, Va.

**Mingo**

Manual Angco — Williamson
Jose S. Espanol — "

**Monongalia**

Edward S. Brezina — Morgantown
Jin Chul Kim — "
Joseph F. Nataro — "
Raymond J. Thabet — "
Kaye Thompson Whitaker — "

**Ohio**

Larry R. Cain — Wheeling
Srinivasan Govinda — "
Robert N. Lewis — "
Alden G. McBee — "
John H. Mahan — "
Edward P. Polack — "
Robert A. Porterfield — "
Vilja K. Stein — "

**Parkersburg Academy**

James M. Beane — Parkersburg
Billy F. Gardner II — "
Paul Kupferberg — "
Nikunj Shah — "
Adam Toppercer — "
Laura Toppercer — "
Paul E. Van Dyke — "
Anantrai Vora — Grantsville
Brian Whalin — Parkersburg

**Potomac Valley**

Inder Khurana — Keyser
Jeffrey S. Life — Romney
Clinton L. Rogers — Cumberland, Md.

**Preston**

Clark Curtis Hunt — Kingwood

**Raleigh**

Joseph Carozza — Beckley
Mohammad Sobhan — "
Manuel B. Villanueva — "

**Summers**

T. H. Mirza — Hinton

**Tygart's Valley**

Harriet Gregor — Elkins
C. S. Kadakia — Philippi
Dudley H. Lonngren — "
Philip J. Zurlo — Elkins

**Student Members**

A 1979 constitutional amendment granted membership in the State Medical Association, effective January 1, 1980, to medical students, and the following is a list of those members:

Arif Amir Alidina — WVU, Morgantown
James Allen Arnett — " "
Marc Alan Bates — " "
William Claude Bird — " "
Susan E. Bonfile — " "
Michael W. Burkhart — " "

| | |
|---|---|
| Stephen Harold Bush | WVU, Morgantown |
| C. Richard Daniel, Jr. | " " |
| Samuel R. Davis | MU, Huntington |
| William Douglas Given | " " |
| J. David Haddox | WVU, Morgantown |
| Jeffrey Paul Hogg | " " |
| Gavin N. Hogue | " " |
| Robert Ward Keefover | MU, Huntington |
| Douglas E. Lemley | WVU, Morgantown |
| William L. Manion | " " |
| Leeman P. Maxwell | " " |
| Daniel Franklin Miller | " Charleston |
| Larry Wayne Moreland | " Morgantown |
| Lee A. Pyles | " " |
| Liane Sher | " " |
| Jeffrey Lynn Stambough | " Charleston |
| Jack Ross Steel | " Morgantown |
| Ron D. Stollings | MU, Huntington |
| Sandra Lee Tabor | " " |
| Philip N. Zambos | " " |

## Licensure, Discipline Featured In New Practice Act

The state's new Medical Practice Act which became effective July 1 represents the most extensive revision of the statute governing the licensing of doctors of medicine in West Virginia in at least 50 years.

The law gives the new Board of Medicine, the successor to the Medical Licensing Board of West Virginia, extensive new and enumerated powers designed not only to protect the public but also to give individual physicians procedural and substantive protection of their rights. The Board now must develop administrative rules and regulations to assure complete implementation of the statute.

From a practical standpoint, the new law can be separated into two general areas—licensing and discipline. A special article in the scientific section of this issue of *The Journal* details those provisions dealing with the disciplinary machinery, and new procedures the Board may use in handling impaired physician problems.

The statute, while establishing separate criteria, combines in one chapter of the state code licensing procedures for both doctors of medicine and surgery, and podiatry. The Board of Medicine is composed of eight doctors of medicine, two podiatrists, two lay members and the State Director of Health, who also continues, by law, to serve as the Board's Secretary.

Although an ex offico Board member, the Director of Health, along with other members, has the right to vote on all issues brought before the body.

Key provisions in the statute are new reporting requirements placed upon hospitals, medical societies and others to report to the Board disciplinary actions, including restriction of privileges, when such action stems from matters of professional ethics, medical incompetence, malpractice, moral turpitude or drugs or alcohol abuse.

These reports serve as triggering mechanisms on which the Board can make its own investigations, to hold hearings and, if such is deemed warranted, to restrict or revoke licenses to practice medicine and dentistry.

The preamble to the new act says that the Legislature "hereby finds and declares that the practice of medicine and surgery and the practice of podiatry is not a natural right of individuals. As a matter of public policy, it is necessary to protect the public interest through enactment of this article and to regulate the granting of such privileges and their use."

During legislative debate on the new statute, considerable discussion centered about means of identifying and dealing with problems involving impaired physicians, including means for providing professional assistance and rehabilitation.

The statute now is designed to achieve these goals through specific investigative, hearing and

**West Virginia's delegation to the annual American Medical Association meeting in Chicago in July used breakfast caucuses to prepare for issues upcoming on the floor of the House of Delegates. Shown reviewing resolutions and reference committee reports are (left to right) Drs. Frank J. Holroyd of Princeton, one of the state's two AMA Delegates, and Jack Leckie of Huntington and Harry S. Weeks, Jr., of Wheeling, Alternate Delegates. Others in the West Virginia delegation were Drs. Stephen D. Ward of Wheeling, President of the State Medical Association; L. Walter Fix of Martinsburg, President Elect, and Richard E. Flood of Weirton, Delegate, along with Executive Secretary Charles R. Lewis. Doctor Weeks also was an unsuccessful candidate for election to the AMA's Council on Medical Service.**

appeal procedures, while in certain limited instances also providing for automatic revocation of a license.

Specifically, the law stipulates that the Board "shall revoke the license of any physician or podiatrist . . . who is found guilty by any court of competent jurisdiction of any felony involving prescribing, selling, administering, dispensing, mixing or otherwise preparing any prescription drug, including any controlled substance under state or federal law, for other than generally accepted therapeutic purposes. . . . A plea of nolo contendere (no contest) has the same effect as a verdict or plea of guilt."

In the licensure area, there are new provisions placing specific limitation on issuance of temporary permits. Other licensing provisions are carried over from previous statute. The Board of Medicine will be preparing further information for physicians as administrative rules and regulations for licensure and other provisions take shape.

## AMA Opposes Senate Committee Medicaid Provision

A provision barring freedom of institutional choice for Medicaid patients has provoked the strong opposition of the American Medical Association.

Approved by the Senate Finance Committee as part of a budget-cutting package, the controversial provision would repeal the present right of Medicaid patients to exercise free choice in selecting qualified suppliers of medical services. The amendment authorizes states to limit access to care to certain hospitals and other providers.

Although the provision would set an important precedent involving freedom of choice and raises again the question of a two-tier health system, it scarcely was noticed by the public press in the hectic scrambling of a Congress that wishes to be elsewhere than Washington in this election year, the AMA commented.

In a letter to committee Chairman Russell Long, Louisiana Democrat, the AMA said the provision "would change the entire thrust and philosophic basis for the Medicaid program. Rather than continuing the program as designed, to provide access to mainstream medical care for the poor, it would authorize a two-tiered system of providing care—one for the general public and another for the poor."

James H. Sammons, M. D., AMA Executive Vice President, said this major redirection of the program is "highly undesirable."

Doctor Sammons called for public hearings and opportunity for consideration by the public and the committee. "We deplore such precipitous action that would have the long-term effect of institutionalizing a two-tiered system of care," he said.

The provision is characterized as affecting only institutional services, but "in our view this proposal would necessarily effectively limit the patient's choice of physician as well," he said. This result is inevitable since patients will be limited to physicians having admitting privileges at the 'Medicaid Hospital'."

The AMA believes that the Medicaid proposal "is an ill-conceived proposal that would bar Medicaid patients from mainstream medical care. Any benefits from cost-savings that would be achieved are overcome by the negative impact that this provision would have on the poor through the establishment of a separate health care system for the poor."

## New, Safer Rabies Vaccine Approved By FDA

The Food and Drug Administration recently announced its approval of a safer and more effective vaccine against human rabies.

Thousands of people receive rabies vaccine each year after being bitten by a dog or other animal. A person bitten by a rabid animal who does not receive the vaccine could die.

The new vaccine is produced from viruses grown in cultures of human cells. The presently-available vaccine is produced in duck eggs.

The new vaccine provides immunity after just five injections in nearly all people bitten by a rabid animal. The duck egg vaccine is less efficient in producing immunity, and requires 23 injections.

In addition, adverse reactions associated with the new vaccine are less frequent than with the duck egg vaccine and other older types of vaccine still used in some countries.

The new vaccine is administered in the arm and, like existing vaccines, is given along with another product called rabies immune globulin, a blood plasma that provides temporary protection for people bitten by a rabid animal.

Studies conducted in the late 1970s in Germany and Iran confirmed the safety and effective-

ness of the vaccine. Of 76 people bitten by rabid animals, none developed rabies.

The new vaccine also can be used in people who are at high risk of being bitten by rabid animals or exposed to rabies virus. These people include veterinarians, animal handlers, laboratory workers and people visiting certain foreign countries. For this type of pre-exposure immunization, only three inoculations are needed. If later exposed, the person would need to receive two more shots.

The vaccine is made by the Institut Merieux, Lyon, France, by a process developed by scientists at the Wistar Institute in Philadelphia. The vaccine will be distributed in the United States by Merieux Institute, Miami, Florida.

Initial distribution will be to various government facilities. The distribution system is being developed by Merieux Institute in cooperation with state health departments, and information on distribution will be available from these health departments at a later time.

## Block Of Access To PSRO Documents Sought

Legislation now before Congress would block unlimited public access to Professional Standards Review Organization (PSRO) documents.

The American Medical Association has urged Congress as part of its 18-part package of PSRO changes to specify that PSROs are not federal agencies and therefore not subject to requirements of the Freedom of Information Law.

A Court of Appeals decision is pending on the issue in Washington, D. C.

The PSRO provision is part of the Medicare-Medicaid amendments measure approved by the House Commerce and Ways and Means Committees. Though it does not take the non-federal agency route of the AMA proposal, the amendment's procedures for court orders to obtain information would serve much the same effect.

Seven of 25 AMA-developed PSRO amendments were substantially adopted in the last Congress.

The 18 amendments pending would authorize organizations, including foundations, to be designated by medical societies as specifically eligible for consideration as PSROs; and authorize physician polling on agreements between PSROs and the government. Many current provisions relating to PSRO operations would be deleted or modified under the AMA proposals.

# *Medical Meetings*

Sept. 3-6—Am. Assn. of Obstetricians & Gynecologists, Hot Springs, Va.

Sept. 4-5—Diagnostic Ultrasound in Obstet.-Gynecol., Johns Hopkins, Baltimore.

Sept. 8—William E. Irons, M. D., Surgical Symposium, Huntington.

Sept. 8-10—Am. Neurological Assn., Boston.

Sept. 11-12—40th Annual Congress on Occupational Health of the AMA, Salt Lake City.

Sept. 21-25—Am. College of Radiology, New Orleans.

Sept. 27-29—Drug in Medical Practice (AMA theme meeting), Kansas City, Mo.

Sept. 28-Oct. 3—Am. Society of Plastic & Reconstructive Surgeons, New Orleans.

Oct. 4-9—AAFP, New Orleans.

Oct. 9-11—Am. Cancer Society, Los Angeles.

Oct. 10-12—Pediatric Approach to Common Neurological Problems (Johns Hopkins), Ocean City, Md.

Oct. 16-17—Geriatric Conference (MU School of Med.), Huntington.

Oct. 17-19—AMA Regional Meeting, Huron, Ohio.

Oct. 19-24—ACS Clinical Congress, Atlanta.

Oct. 24-26—AMA Regional Meeting, Philadelphia.

Oct. 26-30—Am. College of Chest Physicians, Boston.

Oct. 29-Nov. 1—Fourth National Conference on the Impaired Physician (AMA, Med. & Chirurgical Faculty of Md.), Baltimore.

Nov. 2-7—Am. Academy of Ophthalmol., Chicago.

Nov. 9-13—International Congress for Interferon Research, Washington, D. C.

Nov. 12-15—Am. Heart Assn., Miami.

Nov. 13-15—Southern Thoracic Surgical Assn., White Sulphur Springs.

Nov. 13-15—A National Forum on Comprehensive Cancer Rehabilitation and its Vocational Implications (Va. Dept. of Rehabilitative Services, MCV), Williamsburg, Va.

Nov. 14-16—AMA Regional Meeting, New York City.

Nov. 16-19—Southern Med. Assn., San Antonio, Texas.

**1981**

**Jan. 23-25—14th Mid-Winter Clinical Conference, Charleston.**

Feb. 22-25—Southeastern Surgical Congress, New Orleans.

March 8-12—Society of Head & Neck Surgeons; and Am. Society for Head & Neck Surgery, Phoenix, Ariz.

April 8-11—Tenn. Med. Assn., Knoxville.

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

# EQUAGESIC® ©

## (meprobamate and ethoheptazine citrate with aspirin) Wyeth

**EQUAGESIC—Abbreviated Summary**

*__INDICATIONS:__ Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows
"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache
Final classification of the less-than-effective indications requires further investigation
The effectiveness of Equagesic in long-term use, i.e more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

**CONTRAINDICATIONS:** Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

**WARNINGS**: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs
Excessive and prolonged use in susceptible persons, e g , alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures
Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination
**USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.**
**Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.**
Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

**PRECAUTIONS**: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

**ADVERSE REACTIONS**: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug
Impairment of accommodation and visual acuity has been reported rarely

**OVERDOSE**: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

**DESCRIPTION**: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication.

**Wyeth Laboratories**
Philadelphia, Pa 19101

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**WYGESIC—Abbreviated Summary**
**INDICATION**: For the relief of mild-to-moderate pain
**CONTRAINDICATION**: Hypersensitivity to propoxyphene or to acetaminophen
**WARNINGS**: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
**DRUG DEPENDENCE**: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.
**USAGE IN AMBULATORY PATIENTS**: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.
**USAGE IN PREGNANCY**: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
**USAGE IN CHILDREN**: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
**PRECAUTIONS**: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
**ADVERSE REACTIONS**: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
**DRUG INTERACTIONS**: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
**MANAGEMENT OF OVERDOSAGE**: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
**TREATMENT**: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. If has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237 2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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# WVU Medical Center
# –News–

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## New Medicine, Ob-Gyn Faculty Members

New faculty members recently were announced by the West Virginia University School of Medicine.

Three assistant professors have joined the Department of Medicine's Section of Cardiology.

Anthony Morise, M. D., comes to WVU from the University of Vermont, where he received his medical degree and recently completed his cardiology training as a Vermont Heart Association teaching fellow.

He served his internship and residency in internal medicine at the Medical University of South Carolina.

Drs. Michael V. O'Keefe and John J. Wurtzbacher are graduates of the WVU School of Medicine, and completed postgraduate study in internal medicine and fellowships in cardiology at WVU.

Both are members of Alpha Omega Alpha honor medical society.

Drs. Joseph A. Fontana and James A. Knost have joined the faculty as Assistant Professors of Medicine in the Section of Hematology/Oncology.

A graduate of Wayne State University, Doctor Fontana holds a doctorate in biochemistry from Johns Hopkins University, and was engaged in research at the National Institutes of Health before entering the University of Pennsylvania Medical School.

He completed his postgraduate training in internal medicine at Case Western Reserve University, and is the co-author of 10 publications detailing his research.

Doctor Knost is a graduate of Louisiana State University School of Medicine.

He comes to WVU from Vanderbilt University where he completed his postgraduate training in internal medicine and medical oncology.

His primary research areas include clinical trials of cancer treatment, especially of head and neck and other solid tumors.

Juan L. Granados, M. D., has been named Associate Professor of Obstetrics and Gynecology.

Born in Seville, Spain, Doctor Granados received his medical degree from the University of Madrid where he also had three years of training in obstetrics and gynecology.

He comes to WVU from the University of Maryland where he had additional training in his specialty, served on the faculty for six years, and was Chief of the Division of Maternal-Fetal Medicine.

**West Virginia University's new mass spectrometry facility in the Medical Center is put to work by Bob Smith, Manager, and Mary Wimmer, Director. Primary funding for the facility, which includes $200,000 worth of instrumentation, was a grant from the National Institute of General Medical Sciences. The spectrometer and its interfaced chromatographs and data processing system are used for quantitative and qualitative analysis of a wide variety of compounds encountered in the WVU sciences research programs.**

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# Third-Party News, Views and Program Concerns

## First NCI Clinical Trial Of Laetrile Started

The first clinical trial of the possible effectiveness of laetrile (amygdalin) in the treatment of cancer has begun, the National Cancer Institute announced recently.

The NCI clinical trial will be carried out simultaneously at four cancer research centers, under the direction of the NCI Investigational Drug Branch of the Cancer Therapy Evaluation Program.

In the course of the study, about 200 cancer patients for whom no other treatment has been effective will be given laetrile together with a special diet and supplemental vitamins. The study could take up to two years to complete.

Laetrile, as the chemical amygdalin has come to be known, is a naturally occurring plant product containing glucose, a common sugar. The amygdalin molecule can release hydrogen cyanide, a common poison, when the molecule breaks down in the body. Laetrile is found in the kernels of bitter almonds, apricots, peaches, and plums.

The clinical trial with laetrile will follow the same testing approach used with other compounds being tested by NCI for effectiveness in treating cancer. Criteria for selecting patients for the laetrile study are similar to the criteria used for all initial studies of effectiveness of other compounds in the treatment of cancer.

The clinical trial will include patients for whom no established treatment has been demonstrated to be effective. This includes patients who no longer respond to effective drugs, as well as patients for whom no proven treatment exists.

Before permitting the efficacy testing of the drug, the U. S. Food and Drug Administration last spring required a test of laetrile for possible toxic effects in a small number of cancer patients. This test was conducted with six patients at the Mayo Clinic to determine whether administration of the drug together with a special diet and supplemental vitamins might be associated with adverse affects.

Five of the six patients experienced no toxic effects that could be directly or indirectly ascribed to laetrile therapy. The sixth patient showed clinical evidence of toxicity only after eating large quantities of raw almonds, part of a special diet.

## Metropolitan Requests Direct Filing For GM Retirees

Metropolitan Life Insurance Company is asking the cooperation of physicians in the direct filing of claims with Metropolitan for patients who are General Motors retirees or surviving spouses.

Through an arrangement with the government and the carriers handling Medicare Part B, Metropolitan has developed a special claims processing system for the patients specified above.

The direct filing with Metropolitan may be done using Metropolitan and/or standard billing forms. Metropolitan will pay the provider the reasonable and customary fee for covered services rendered. There are no deductibles and no co-payments involved (with the exception of outpatient psychiatric services).

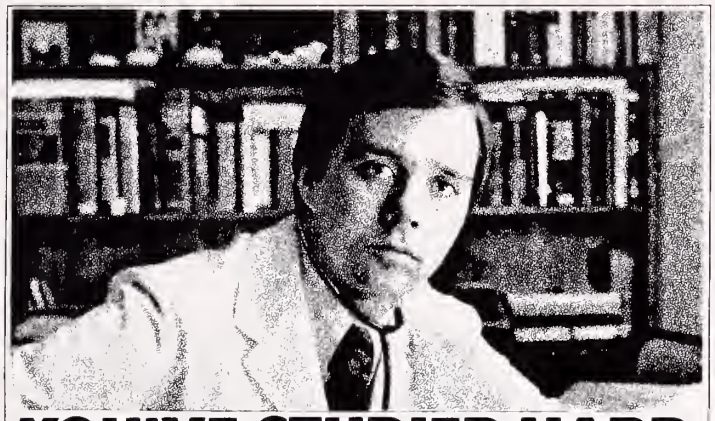
Retirees and spouses enrolled in the "General Motors Retiree Health Care Servicing Program" have been issued a distinctive identification card.

For additional information, call (800) 241-9964.

## Califano New Lobbyist

Now lobbying for home health care firms are Joseph A. Califano, Jr., former HEW Secretary, and his law partner, Ben W. Heineman, Jr., former Assistant HEW Secretary.

The Washington Star reports they have been retained by Quality Care, a chain with 190 offices, in an effort to get Medicare reimbursement for home-care services in every state.



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**Brief Summary**

**INDICATIONS:** For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

**CONTRAINDICATIONS:** Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

**PRECAUTIONS:** Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication. Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

**ADVERSE REACTIONS:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

**DOSAGE AND ADMINISTRATION:**
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

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# Obituaries

### RICHARD D. KITCHING, M. D.

Dr. Richard D. Kitching, Charleston psychiatrist, died on July 22. He was 56.

Doctor Kitching had practiced in Charleston since 1963.

A native of Brooklyn, New York, he received his M. D. degree in 1954 from the University of Washington School of Medicine. He interned at Kings County Hospital Center in Brooklyn, and served his residency at Letterman General Hospital in San Francisco.

Doctor Kitching was a psychiatrist for the U. S. Army Medical Corps for more than six years.

He was a member of the Kanawha Medical Society, the West Virginia State Medical Association, American Medical Association and American Group Psychotherapy Association.

Survivors include the widow; three sons, Briton H. Kitching of Westminster, Colorado; Richard A. Kitching of Lewisburg and Scott W. Kitching of Shepherdstown; a daughter, Lori Conrad of Lewisburg; two stepdaughters, Barbara R. Thomas and Julia L. Thomas, both of Charleston, and a brother, Porter E. Kitching of New York City.

* * *

### MARY V. GALLAGHER, M. D.

Dr. Mary V. Gallagher, Charleston pediatrician, died on July 29 at her home there. She was 65.

Doctor Gallagher was employed by the West Virginia State Department of Health from 1969 to 1979, when she retired.

A native of South Charleston, she was graduated from West Virginia University and received her M. D. degree in 1941 from the Medical College of Virginia.

Doctor Gallagher was a retired member of the Kanawha Medical Society and the West Virginia State Medical Association.

Surviving are three nephews, Tom Gallagher of Culloden (Cabell County), Martin Gallagher of Cincinnati, and Robert Gallagher of Morgantown.

(Continued on next Page)

OBITUARIES—*Continued*

### CARL B. JARRELL, M. D.

Dr. Carl B. Jarrell of Charleston died on August 3 in a hospital there. He was 57.

Director of Employee Health at St. Francis Hospital, Doctor Jarrell had practiced in Charleston for 27 years.

A native of Comfort (Boone County), he was graduated from Marshall University and received his M. D. degree in 1952 from Tulane University School of Medicine. He interned at Charleston General Hospital.

An Air Force World War II veteran, Doctor Jarrell was a member of the West Virginia State Medical Association.

Survivors include the widow; two daughters, Mrs. Sandra Emanuel of Chevy Chase, Maryland, and Miss Judith Jarrell, at home; three sons, C. B. Jarrell of Madison, Gary Jarrell, at home, and Mark Jarrell of Dunbar; and three sisters, Mrs. Martha Foster of Charleston, Mrs. Marie Eddy of Zanesville, Ohio, and Mrs. Mary Jo Mosser of Fort Lauderdale, Florida.


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# Book Review

**MOOD DISORDERS: THE WORLD'S MAJOR PUBLIC HEALTH PROBLEM** — edited by Frank J. Ayd, Jr., M.D., and Irving J. Taylor, M.D. 261 pages. Price $18.50. Ayd Medical Communications, Baltimore, Maryland. 1978.

Consisting of 16 chapters by 19 authors, many of whom are quite well known in Psychiatry, this book contains the proceedings of the 1978 Taylor Manor Hospital scientific symposium on Mood Disorders. Although many collections of scientific proceedings appear rather disorganized due to individual chapters overlapping or competing with each other, this is not the case here. Not only are many of the chapters quite excellent taken in their own right, but the book's organization is such that a certain flow and rhythm are achieved as well.

The initial chapters deal with epidemiology and the biological aspects of mood disorders, particularly depression, and emphasize two major facts. The first is that mood disorders are a very frequent and under-diagnosed illness, being present in about six per cent of women and three per cent of men throughout the world. Secondly, major depressive illness is a medical disease with a genetic predisposition and is mediated via aberrant neurochemistry. In order to treat major depressions as effectively and agressively as necessary, physicians must recognize that they are a medical illness quite distinct from the normal experience of unhappiness or from being "too weak to handle stress."

The middle chapters of the book deal with specific areas of depression such as child, adolescent, and geriatric mood disorders. Next are discussions of treatment modalities such as antidepressant medications, ECT, and a superb chapter on risks versus benefits of lithium treatment and prophylaxes by Mogens Schou. Jan Fawcett's chapter on "Saving the Suicidal Patient" is an interesting analysis of risk factors, both acute and chronic, used clinically to assess and then reduce suicide risk. As usual, his presentation is thorough but not totally obfuscated by the complexity of this area.

Although some of these chapters will be of primary interest to psychiatrists, others such as Fred Goodwin's excellent overview of the extremely diverse psychobiology and biologic concomitants of mood disorders, will be equally interesting to the generalist or internist. Joe Talley, a family practitioner from North Carolina, presents a chapter on "Depression as Seen in Family Practice." His view is that family practitioners should treat major depression more agressively with antidepressant medications rather than obsess over insight, family dynamics, or various psychotherapy modalities, concepts about which he has had just enough exposure to become either intimidated or cynical. I am in total agreement with this view and with his belief that the chief complaint of most significantly-depressed patients presenting to general physicians is not depressed mood; more likely, the chief complaint will be unexplained somatic complaints of several weeks' duration, or fatigue and energy loss.

Nearly all of the individual chapters are well worth reading by themselves. Doctor Ayd has organized them coherently into a book which represents one of the best available references on mood disorders.—Edmund C. Settle, Jr. M.D.

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**THE HANDBOOK OF OBSTETRICS AND GYNECOLOGY, SEVENTH EDITION** — by Ralph C. Benson, M. D. 807 pages. Price $10. Lange Medical Publications, Los Altos, California 94022. 1980.

The Seventh Edition of *The Handbook of Obstetrics and Gynecology* is stated to be an extensive revision of the Sixth Edition with additional material. It is intended "to present to the medical student, resident, nurse practitioner, midwife, and busy physician a concise and readily available digest of material necessary for the diagnosis and treatment of obstetrical and gynecological problems."

Doctor Benson is the Emeritus Chairman of the Department of Obstetrics and Gynecology at the University of Oregon Health Sciences Center in Portland. As such, he is eminently qualified to do the editing and revision of this book; however, it suffers from the fact that one man is attempting to cover every aspect of the field of obstetrics and gynecology. For example, on Page 235, in the discussion of suppression of postpartum lactation, Bromocriptine (Parlodel) simply is added in the drug table with no discussion of its use in the text. On the following pages, it is not mentioned at all in the discussion of Galactorrhea where its use was first approved by the Federal Drug Administration.

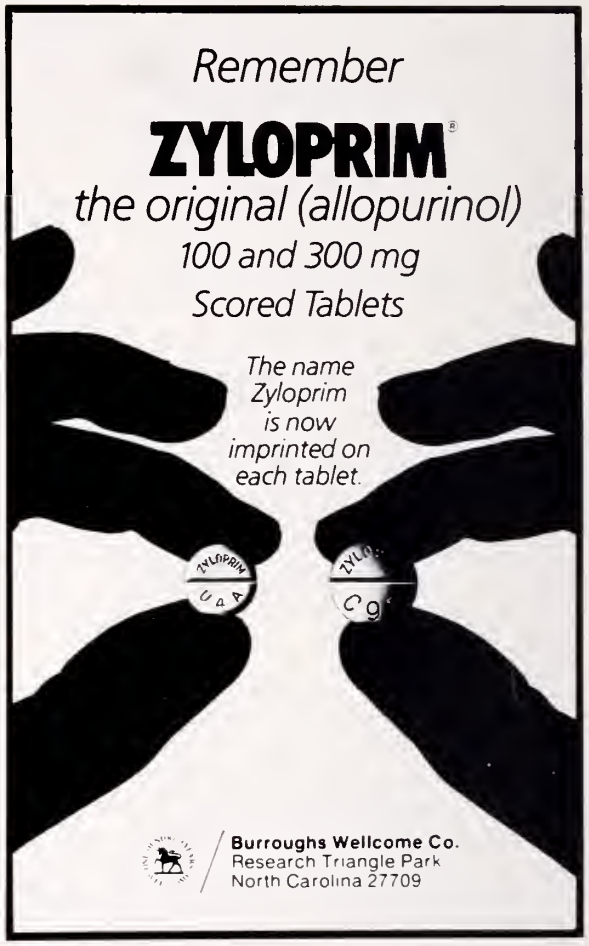
This handbook is a soft-bound manual which can be carried easily in an obstetrical bag or in the hand of a student or practitioner. Reference can be made to the material contained within it either from the Table of Contents or the index; however, I had difficulty in finding a straightfor-

ward discussion of trichomoniasis from the index. Once the sought-for material is found, it is accurate and agrees with the discussions found in larger textbooks such as *Eastman's Obstetrics.*

In spite of the fact that it is the 1980 Edition, some of the newer material in the field of obstetrics and gynecology has not been covered adequately. For example, there is no mention of the use of cryoprecipitates in the discussion of consumptive coagulopathy on Page 263. Occasionally, newer material (e.g., Parlodel, immunization tests of pregnancy) is included in tables prepared for the text but not discussed.

In his discussion of the conduct of normal labor and delivery, Doctor Benson recommends sedation and diazepam, 10 mg. prior to the use of analgesia or anesthesia. I believe the newer graduates of today's residency program would question the use of diazepam in this manner. In this regard, one feels that Doctor Benson is writing from his personal experience of five to 10 years ago, so that some of the recommendations made in the book already are out of date at the time of publication.

In spite of these criticisms, the main content of the book is accurate, concise and readily accessible. For this reason, it is a good handbook for medical students, nurse practitioners and midwives. However, I think it will have limited use for the practicing obstetrician.—T. Keith Edwards, M. D.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**WANTED** — Obstetrician/Gynecologist needed to take over existing practice in progressive community centrally located between Parkersburg and Charleston. Nine year old modern 80 bed hospital with latest equipment and facilities. Hospital is willing to negotiate financial arrangements and office space. Excellent opportunity for young physician wishing to establish active practice. Contact Robert M. Carper, Administrator, Roane General Hospital, 200 Hospital Drive, Spencer, WV 25276. Telephone: (304) 927-4444.

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Charlotte Treatment Center xv

Eye & Ear Clinic of Charleston, The xix

Golden Clinic, The xviii

Harding Hospital, The xxii

Kanawha Valley Bank, N.A. xvi

Lilly, Eli, and Company viii

McDonough Caperton Shepherd Association Group xi

Merck Sharp & Dohme *Insert*

Merrell-National, Inc. vi, *Insert*, xiv, *Insert*

Myers Clinic, The xvi

Pathology Associates Laboratory iv

Prince Medical Reference Laboratories ix

Roche Laboratories ii, iii, *Insert, Inside Back Cover, Back Cover*

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# The West Virginia Medical Journal

*Official Publication of the West Virginia State Medical Association*

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**MEMBER, WEST VIRGINIA PRESS ASSOCIATION, 1980**

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# CONTENTS

PRESIDENTIAL ADDRESS—Stephen D. Ward, M. D. 253

**Scientific Articles**

The Treatment of Acute Leukemia in Adults—Brian K. Walker, M. D.; and Peter C. Raich, M. D. 257

Primary Choriocarcinoma of the Lung (A Case Report)—Ahmed H. Kalla, M. D.; Edward C. Voss, Jr., M. D.; and Robert J. Reed III, M. D. 261

**The President's Page**

The Many Facets of Insurance—L. Walter Fix, M. D., President, W. Va. State Medical Association 264

**Editorials**

States' Rights 265
New Boost For VE 265
Quality Assurance 266

**General News**

Dr. L. Walter Fix Assumes Presidency 267
Delegates Approve Amendments 269
14th Mid-Winter Clinical Conference 271
MU Critical Care Conference 272
Committee Appointments 273
Mrs. Gary G. Gilbert Heads Auxiliary 278
AMA House Action 279
1981 Association Meeting to be Cut One Day 280
Proposed Amendments 282

**Special Departments**

WVU Medical Center News xii
Third-Party News, Views, Program Concerns xiv
Obituaries xvi
County Societies xvi
Resolutions xvii
Necrology Report xviii
Classified Section xxiv
Index To Advertisers xxvi

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Brief Summary

**INDICATION** Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short term adjunct a few weeks in a regimen of weight reduction based on caloric restriction The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

**CONTRAINDICATIONS** Advanced arteriosclerosis hyperthyroidism known hypersensitivity or idiosyncrasy to the sympathomimetic amines glaucoma Agitated states Patients with a history of drug abuse During or within 14 days following the administration of monoamine oxidase inhibitors hypertensive crises may result

**WARNINGS** If tolerance develops the recommended dose should not be exceeded in an attempt to increase the effect rather the drug should be discontinued Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle the patient should therefore be cautioned accordingly *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused There have been reports of subjects becoming psychologically dependent on diethylpropion The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which in the case of certain drugs may be severe There are reports of patients who have increased the dosage to many times that recommended Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression changes are also noted on the sleep EEG Manifestations of chronic intoxication with anorectic drugs include severe dermatoses marked insomnia irritability hyperactivity and personality changes The most severe manifestation of chronic intoxications is psychosis often clinically indistinguishable from schizophrenia *Use in Pregnancy* Although rat and human reproductive studies have not indicated adverse effects the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks *Use in Children* Tenuate is not recommended for use in children under 12 years of age

**PRECAUTIONS** Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias Tenuate should not be administered to patients with severe hypertension Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen Tenuate may decrease the hypotensive effect of guanethidine The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage Reports suggest that Tenuate may increase convulsions in some epileptics Therefore epileptics receiving Tenuate should be carefully monitored Titration of dose or discontinuance of Tenuate may be necessary

**ADVERSE REACTIONS** *Cardiovascular* Palpitation tachycardia elevation of blood pressure precordial pain, arrhythmia One published report described T wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride *Central Nervous System* Overstimulation nervousness, restlessness dizziness jitteriness insomnia, anxiety euphoria depression dysphoria tremor dyskinesia mydriasis drowsiness, malaise headache rarely psychotic episodes at recommended doses In a few epileptics an increase in convulsive episodes has been reported *Gastrointestinal* Dryness of the mouth unpleasant taste nausea vomiting abdominal discomfort, diarrhea constipation, other gastrointestinal disturbances *Allergic* Urticaria, rash, ecchymosis erythema *Endocrine* impotence changes in libido, gynecomastia menstrual upset *Hematopoietic System* Bone marrow depression agranulocytosis, leukopenia *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians These include complaints such as dyspnea hair loss, muscle pain dysuria increased sweating and polyuria

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**References** 1 Citations available on request from Medical Research Department MERRELL NATIONAL LABORATORIES Cincinnati, Ohio 45215 2 Hoekenga M T O Dillon Dillon R H and Leyland H M A comprehensive review of diethylpropion hydrochloride In Central Mechanisms of Anorectic Drugs S Garattini and R Samanin Ed New York Raven Press, 1978 pp 391-404

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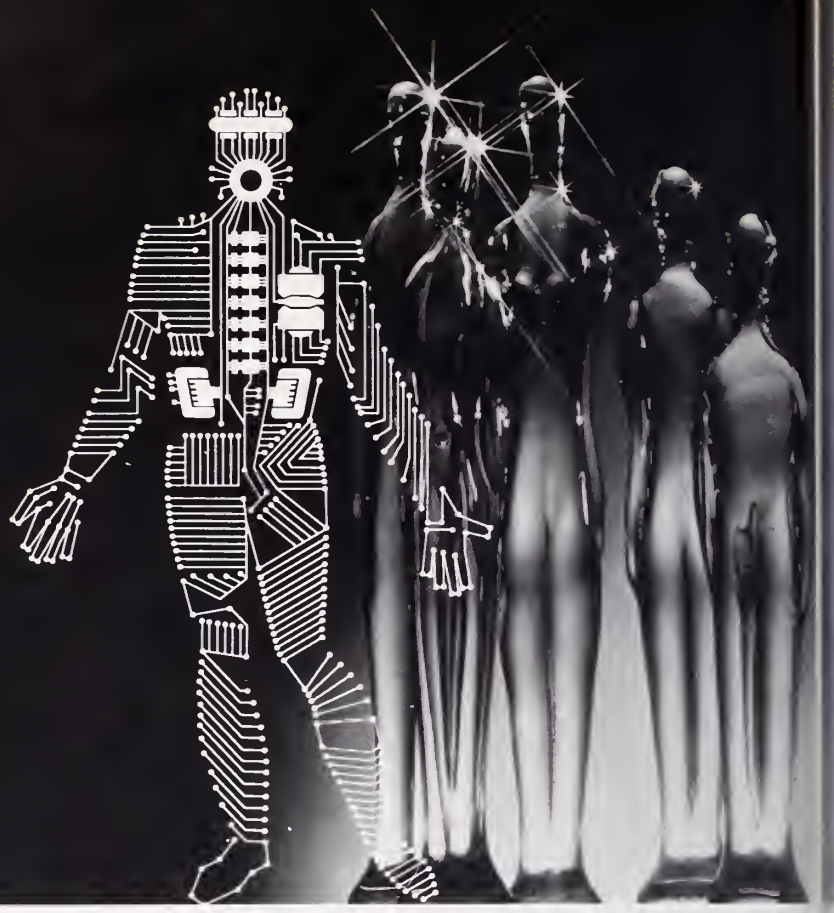

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Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

**Catapres®**
**(clonidine hydrochloride)**
**Tablets of 0.1, 0.2, 0.3 mg**

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
*Usage in Children:* No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mon longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsines sedation. Constipation, dizziness, headache, and fatigue have been repo Generally these effects tend to diminish with continued therapy. The follo reactions have been associated with the drug, some of them rarely. (In instances an exact causal relationship has not been established.) These inc Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalit liver function tests; one report of possible drug-induced hepatitis without ic and hyperbilirubinemia in a patient receiving clonidine hydrochloride, thalidone and papaverine hydrochloride. Weight gain, transient elevation of glucose, or serum creatine phosphokinase: congestive heart failure, Rayn phenomenon; vivid dreams or nightmares, insomnia, other behavioral chan nervousness, restlessness, anxiety and mental depression. Also rash gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not assoc with a rash, impotence, urinary retention, increased sensitivity to alcohol, dry itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecom weakly positive Coombs' test, asymptomatic electrocardiographic abnorma manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished sent reflexes and vomiting followed the accidental ingestion of Catapres (clor hydrochloride) by several children from 19 months to 5 years of age. G lavage and administration of an analeptic and vasopressor led to comple covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-m intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) dosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0. (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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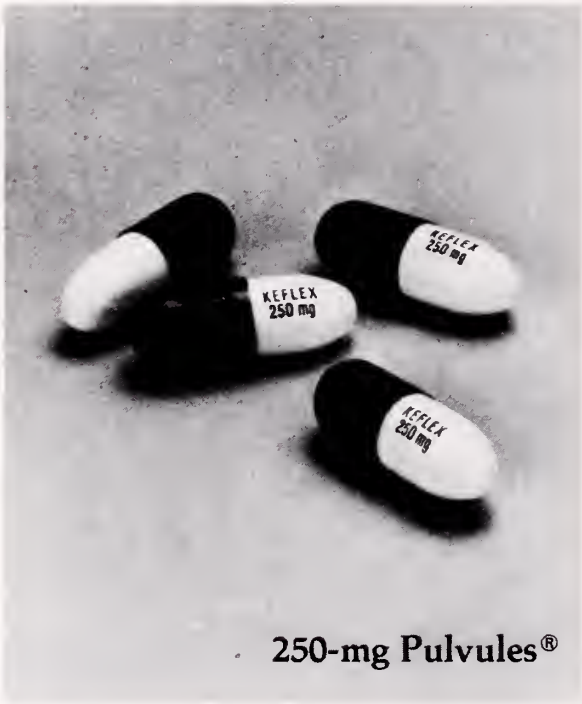


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# EQUAGESIC® ©IV

## (meprobamate and ethoheptazine citrate with aspirin) Wyeth

**EQUAGESIC—Abbreviated Summary**

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i.e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient.

**CONTRAINDICATIONS:** Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

**WARNINGS:** Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination

**USAGE IN PREGNANCY AND LACTATION An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.**

**Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.**

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

**PRECAUTIONS:** Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

**ADVERSE REACTIONS:** A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

**OVERDOSE:** Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

**DESCRIPTION:** Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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# WHY NOT WYGESIC® CIV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

**WYGESIC—Abbreviated Summary**

**INDICATION**: For the relief of mild-to-moderate pain

**CONTRAINDICATION**: Hypersensitivity to propoxyphene or to acetaminophen

**WARNINGS**: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Menagemant of Overdosege**).

**DRUG DEPENDENCE:** Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

**USAGE IN AMBULATORY PATIENTS**: Propoxyphene may impair the mental and or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery Patients should be cautioned accordingly

**USAGE IN PREGNANCY**: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards

**USAGE IN CHILDREN:** Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

**PRECAUTIONS:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

**ADVERSE REACTIONS:** The most frequent adverse reactions are dizziness, sedation, nausea, end vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these ractions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions Cases of liver dysfunction have been reported.

**DRUG INTERACTIONS:** Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

**MANAGEMENT OF OVERDOSAGE:** SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning Cardiac arrhythmias and pulmonery edema have occasionally been reported, and apnea, cardiac errest, and death have occurred

Symptoms of massive overdosage with ecetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported

Ingestion of 10 grams or more of ecetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal

**TREATMENT:** Primary attention should be given to the reestablishment of edequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphen, are specific entidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory In addition to a narcotic entagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly ebsorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since ecetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours) N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237 2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in essessing the likelihood of hepatotoxicity Serial hepatic enzyme determinetions are also recommended.

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The West Virginia Medical Journal

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# Presidential Address*

STEPHEN D. WARD, M. D.
*Wheeling, West Virginia, Immediate Past President, West Virginia State Medical Association*

The 113th year in the history of the West Virginia State Medical Association has been completed. It has been a year marked by significant accomplishments, by significant progress on goals and plans previously set, and by the creation of significant new goals for the Association.

Legislatively, the Association experienced a year of unprecedented accomplishment. For the first time, the Medical Association approached the Legislature with a legislative program of its own. The program consisted of three bills. All three passed and are now law.

The most important of these new laws is the new Medical Practice Act. Under terms of the previous law, initially passed in 1881, West Virginia physicians had suffered an increasing volume of criticism and abuse because of our alleged inability to control the practice of Medicine in West Virginia.

No one argued the fact that from time to time abuse did occur, and the application of corrective measures was called for. The law itself, however, provided legalistic barriers to the rational application of those provisions of the law which might have improved the lot and protected the welfare of the citizens of West Virginia.

Under that law, it was possible for the legal profession to make it difficult, if not impossible, for anyone to control the practice of Medicine. Medicine took the blame and suffered abuse, which, could the facts have been made known, would have been much more appropriately directed at the legal profession. This law was repealed and the new one enacted.

Under the new law, a wide range of options is given the West Virginia Board of Medicine to correct incompetent practice or genuine abuse stemming from any cause. Under the new law, the impaired physician can be treated with dignity and assisted into a true program of rehabilitation. Concern for the rights of all physicians and due process are provided at every stage. Opportunities for the legal system or the courts to obstruct the process are sharply limited.

**Stephen D. Ward, M. D.**

*Presented at the second and final session of the House of Delegates, 113th Annual Meeting of the West Virginia State Medical Association, the Greenbrier, White Sulphur Springs, W. Va., Saturday, August 23, 1980.

With the passage of this law, no longer need the competent and ethical physician in West Virginia suffer the embarrassment of seeming to tolerate incompetence or unethical behavior and practice in someone passing for a colleague. No longer need the profession suffer undeserved criticism for failure to influence matters beyond its control.

A second bill caused to be introduced by the Association and passed into law assures the confidentiality of peer review records maintained at hospitals. Prior to the passage of this law, the attending physician was in jeopardy every time a review body made an adverse comment on one of his patient records. This is an important protection for every physician who hospitalizes patients.

A third Association bill passed into law provides a definition of death when all the findings of criteria for brain death have been met. This law facilitates organ retrieval and transplant. Dramatic reductions in the cost of care can be made in programs such as the End Stage Renal Disease Program when kidneys can be made available and transplant carried out.

#### Favorable Legislative Reaction

A very favorable reaction from legislators resulted from the introduction of this package of bills. Compliments from most unexpected sources were received and appreciated by the State Association. In years gone by the Association had hesitated to sponsor legislation for fear that in the amendment stage, constitutionally unfriendly legislators would seize the opportunity to "doctor" the legislation into something unrecognizable and unwanted.

Physicians and their organizations have correspondingly been regarded by many legislators as simply defensive, self-interested and constitutionally resistant to any change. Experiences of the past year have demonstrated we were both mistaken.

Opportunity for an enlightened era of cooperation and mutual assistance between physicians and legislators has been created during which the citizens of West Virginia can but benefit. I strongly recommend pursuing this opportunity through the preparation of a yearly legislative program and the active advocacy of health interests before the legislature.

During the past year, the incidence of malpractice claims has risen alarmingly. Although the availability of insurance is not now in doubt, the cost of that insurance has become burdensome to the point of unacceptability.

In a litigious climate, with the populace schooled in the conviction that whenever misfortune occurs, someone, somewhere in the world is responsible, with a breed of predatory attorneys athirst to search out that guilty party so that justice might be, and their personal fortunes will certainly be served, it has become incumbent upon us to look to our own best interest.

An in-depth review of the Association-sponsored Professional Liability Program has been carried out in the past year by the Insurance Committee. Advice has been solicited from a variety of experts, and negotiations have taken place with alternative insurance companies. Recommendations of the Insurance Committee and Council are now available to you. I endorse this report and applaud the work of the Insurance Committee during the past year.

Also during the past year, the Association has moved ahead aggressively with plans to construct its own headquarters. An assessment levied by Council to acquire additional property has met with general acceptance by the membership. I strongly recommend the pursuance of these plans to their early completion. Such completion holds promise of stabilizing costs of administering Association services and, perhaps even of subsidizing services in the future.

Chronic problems with the Department of Welfare and its Medicaid Program erupted violently during the past year, and the unhealthy fallout has affected thousands of citizens throughout the State. The problem starts with the political sin of yielding to the temptation of promising more medical care than can be delivered and paid for. Political sinners atone by making physicians do the penance of paying the overage by being forced to accept inadequate fees from Welfare.

#### Point of Diminishing Returns

We were able to demonstrate this year that this system has passed the point of diminishing returns. The conflicting dictates between the economic practicalities of departmental administration and the needs of political strategists in an election year provide a dangerous dilemma for the present Administration. Medicaid in West Virginia simply will cease to function without changes the Administration knows are necessary.

A major goal of my year in office, the message of which I have carried into every corner of the State, has been to make all members of the West Virginia State Medical Association members of the American Medical Association. This goal has

had some partial success. We expect that this year will see the highest number of AMA members in West Virginia in the history of this organization.

This is an important objective and one that deserves rededication yearly. There are countless splintering forces at work within Medicine but just one unifying force. The glue that holds the whole system together is the AMA.

Most physicians belong to some specialty or collegial group. Each takes a narrow look at the interests of its members. These interests are important. They need study, need defining. They need the scrutiny that only those dealing on a daily basis with their ramifications can adequately give in order that those concerns peculiar to that group can be advanced. There are group and solo practice interests; civilian, veterans and military interests; prepaid and fee-for-service interests; town interests and gown. There are ethnic, racial and geographic interests.

But, like some great orchestra preparing to play a symphony, Medicine produces only noise and cacaphony until its conductor, the AMA, lifts the baton and blends all into harmony.

I recommend to you very strongly the advantages of a unified system of membership between the West Virginia State Medical Association and the AMA.

In this political year of 1980, I cannot fail to mention the need for vigorous political advocacy. In West Virginia, the vehicle for this is WESPAC, The West Virginia Medical Political Action Committee, and its parent organization, AMPAC, The American Medical Political Action Committee. I have found it a curiosity in this state, with its rich tradition of political enthusiasm at all levels of society extending into all levels of government, that there is so little active support among West Virginia physicians for WESPAC activities. Physicians in every adjoining state have better records of participation than we here in West Virginia.

The political process is the golden key to the future of our profession. Whether we like or not, this is so. We must find ways to overcome our lethargic political performance here in West Virginia.

No organization can exist long without change. Change for the sake of change or trendy change for the sake of fashion is meaningless at best and destructive at worst. Forced and unexpected change is shattering to the morale of an individual or an organization.

**Long Range Planning**

In recognition of these tenets, the Council of your Association this year established an Ad Hoc Committee on Long Range Planning. This Committee has met and made thoughtful and worthwhile suggestions to Council. I strongly endorse by-laws amendments making the Long Range Planning Committee a standing committee of the Association.

The past year has seen the introduction of several prepaid medical care plans into West Virginia. We welcomed these editorially in *The West Virginia Medical Journal* as adding a new depth and range to the types of services available to the West Virginia public. An initial impression leads me to voice a caution to those West Virginia physicians who choose to involve themselves with such plans.

In discussions among physicians involved in providing prepaid services, I have noted a certain cold, unfeeling, business approach to providing those services. Perhaps it is just a function of my idealistic naivete about Medicine, but never previously had I been aware of a group attitude toward the therapeutic transaction which failed to place primacy on the patient, on his pain or comfort, his anxiety or his ease.

The existence of such an impersonal attitude toward patients within Medicine, even by a group representing such a small part of Medicine and medical practice as those in prepaid medical care, bodes no good for the whole of Medicine. Our use of sophisticated technological equipment in diagnosis and in patient monitoring has exposed all of us to criticism which holds that we lack concern for the individual. Patients complain that they are only a chart number or a case of something they cannot pronounce.

Were the attitude I see arising to prevail, we very well might find ourselves answering those complaints by vainly and foolishly questioning, "Why would that gallbladder in 322 think my care is impersonal? How dare that what's-his-name say that I don't care?"

Medicine is in deep trouble when the patient comes any place but first. We simply cannot ever afford to let the system, or a set of statistics, or a diagnosis, or a fund of money come first in our consideration.

When humanity has been ushered out of the therapeutic transaction and replaced by attention to technique, by concern for statistics and anxiety about costs, we will have lost the support of the general public, our patients. They surely will have turned to that great patron and dispenser

of humanitarian benefits, the Federal Government. And we will then look back on the Golden Age of Medicine and yearn for those days which we now have.

### A Golden Era of Medicine

We are in a golden era of Medicine. Never in the history of this profession, or perhaps any other, has there occurred in a relative few years such a profusion of changes and such an enormous gathering of knowledge. Nor has there ever been a more enthusiastic response to knowledge and change than by both those in this profession and those seeking the benefits of that knowledge and change. It seems a cruel and unlikely paradox that at this time of unprecedented accomplishment and popularity we should also find it necessary to defend, as though besieged, our ability to continue and to further those accomplishments.

No physician is too old to recall the excitement of that day when he graduated from medical school. Medicine never wore more glorious raiment than on that day. Her multifaceted garb glittered and sparkled like jewels catching the sunlight. Her shimmering charms cast an allure which worked an irresistible seduction.

The passage of years tends to jade memory, or even experience, of sensuous feeling. Bureaucratic intrusions by government and other third parties jaundice our appreciation of those delights of Medicine grown familiar with time.

Medicine is *not* less attractive now! We age. Medicine adds beauty and enchantment as its hidden secrets are unveiled. We sag and wrinkle. Medicine adds fullness to its contours.

We are not beyond responding to the seductive charms of medicine. Baring ourselves to a reawakening and reawareness of those commencement feelings which once so thrilled us can rejuvenate that desire we once knew to experience all of her.

And then, perhaps, we will know how to honor, serve and protect this old love of ours.

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## Treatment Can Help Hay Fever Sufferers

MANY people will suffer the tortures of hay fever this fall. And much of the suffering could be avoided, declares the American Medical Association.

There have been predictions that the fall of 1980 will be an especially difficult time for hay fever sufferers, with an above-average pollen count following an unusually wet winter.

Most sufferers still fail to take full advantage of the available remedies, according to a pamphlet on hay fever from the AMA.

The most effective preventive treatment for severe hay fever is shots. This means regular injections of solutions of pollen or other allergy-producing substances, beginning with tiny doses.

AMA Drug Evaluations, the AMA's manual for physicians, points out that antihistamines are effective in the management of hay fever symptoms. Some 70 to 95 per cent of patients experience some relief from runny nose, sneezing, and watery, swollen eyes. There are long-acting preparations that can be taken at bedtime to control the more severe symptoms that are usually evident in the early morning, the AMA book observes.

# The Treatment Of Acute Leukemia In Adults

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*Remarkable progress has been made in the treatment of acute leukemia in adults during the past decade. Modern chemotherapeutic agents have the potential to eradicate, at least temporarily, all evidence of leukemia in the majority of patients. The profound pancytopenia associated with the disease and the intensive therapy frequently lead to complications such as infection and hemorrhage. However, modern techniques of blood component therapy and prompt administration of the new antibiotic agents have greatly reduced the morbidity and mortality for these seriously ill patients. This review is presented to highlight the important advances in chemotherapy, as well as the striking progress in supportive care for patients with acute leukemia.*

In recent years, great advances have been made in the therapy and supportive care of patients with acute leukemia.The newer chemotherapeutic agents, although possessing significant toxicity, have the potential of temporarily eradicating all evidence of leukemia and prolonging survival in the majority of patients. Associated with the initial intensive treatment is a period of profound chemotherapy-induced bone marrow hypoplasia with a high risk of hemorrhage and/or infection. The management of these complications likewise has achieved striking progress. Proper selection of the newer antibiotic agents can combat effectively most of the infectious complications.[1] Similarly, modern techniques of blood component therapy provide platelet and granulocyte transfusions to reduce the incidence of life-threatening hemorrhage and infection.[2]

As a result of these advances, approximately 60 per cent of patients with acute leukemia may attain a complete remission of the disease with a life expectancy now in excess of one year.[3] The overall prognosis, however, for long-term survival remains poor, and intensive investigative efforts continue to seek improved treatment methods.

It should be noted that adult acute leukemia includes both myelocytic and lymphocytic forms. The emphasis of this review will be on the much more common myelocytic form.

### The Chemotherapy Program

The initial goal in treating patients with acute leukemia is to achieve a complete remission, a condition in which all evidence of a leukemic cell population has been eliminated and the patient's health has returned to normal. To attain this goal, intensive induction chemotherapy is administered employing a combination of potent cytotoxic agents. At present, the most effective regimens include cytosine arabinoside (Cytosar) by continuous infusion with an anthracycline, either doxorubicin hydrochloride (Adriamycin) or daunorubicin. The addition or substitution of other agents, such as vincristine (Oncovin), prednisone, 6-thioguanine or cyclophosphamide (Cytoxan), has been advocated, but most reports indicate only minimal advantage over the two-drug regimen.[4,5] The more commonly employed drug combinations and their associated complete remission rates are listed in the Table.

Soon after the initiation of treatment, the majority of patients will become profoundly cytopenic with elimination of both normal marrow elements and leukemic cells. After a period of severe marrow hypoplasia and pancytopenia lasting 7 to 21 days, approximately 60 per cent of patients will repopulate the marrow with normal hematopoietic elements. Soon thereafter, peripheral blood counts return to normal. At this point, patients are in a complete remission, and remain disease-free until relapse occurs, usually 8 to 14 months later.

Experience has demonstrated that eradication of the leukemic cell line is best achieved with very intensive initial chemotherapy and the induction of profound marrow hypoplasia. In

**TABLE**

**Chemotherapy of Adult Acute Leukemia**

| *Drug Regimen* | *Complete Remissions* |
|---|---|
| Ara-C + 6-thioguanine | 40% |
| Ara-C + vincristine + prednisone + cyclophosphamide | 45% |
| Ara-C + daunorubicin | 55% |
| Ara-C + daunorubicin + 6-thioguanine | 65% |

other words, the administration of potent therapy at the outset affords a better chance of complete disease remission and prolonged survival. Less intensive therapy, although associated with reduced immediate morbidity, seldom achieves a complete remission and yields a very brief prolongation of survival.

In the present therapy programs, less intensive maintenance chemotherapy is administered in monthly cycles during complete remission to delay the reappearance of the leukemic cell population. Although some controversy exists regarding the value of maintenance programs, most investigators believe that remission duration is prolonged significantly by such therapy.[6]

The role of immunotherapy in the treatment of acute leukemia has not yet been fully defined. Several reports have suggested a beneficial effect when immunotherapy is used in conjunction with chemotherapy in the maintenance phase. However, conflicting opinion exists regarding the value of immunotherapy and, at present, it can be advocated only in the setting of investigational studies.[7]

The success achieved with the present intensive chemotherapy regimens is certainly encouraging; however, there still remains a substantial number of newly-diagnosed patients who fail to attain a complete remission even after several cycles of induction therapy. Furthermore, the majority of patients who relapse after an initial complete remission are then refractory to all cytotoxic therapy. Adequate treatment for these patients awaits the development and clinical testing of new chemotherapeutic agents and alternative therapeutic modalities.

### Bone Marrow Transplantation

Bone marrow transplantation as a therapeutic approach to acute leukemia has achieved encouraging results in recent years. Patients receive initial intensive chemo- and radiotherapy to eradicate all leukemic as well as normal marrow elements. Transplantation of donor marrow is then accomplished with engraftment of donor hematopoietic cells. At present, marrow transplantation is possible only for those patients with HL-A identical siblings, since incompatible donor cells are promptly rejected by the recipient. Other major problems include graft-versus-host disease, which occurs to some degree in most patients with successful engraftment, and a disturbingly high incidence of recurrent leukemia, on the order of 50 per cent.[8] Nevertheless, there are reports of approximately 30 per cent long-term, leukemia-free patients in several transplantation programs, a number which compares favorably with the best chemotherapy protocols.[9] Despite these obstacles, there is considerable enthusiasm for bone marrow transplantation, and clinical investigation is continuing.

### Supportive Care

The majority of complications encountered by patients with acute leukemia stem from the absence of normal bone marrow elements. At the time of diagnosis the normal hematopoietic precursors are replaced largely by leukemic cells, and most patients demonstrate a combination of granulocytopenia, thrombocytopenia and/or anemia. Subsequently, the potent cytotoxic therapy temporarily will eradicate all remaining normal bone marrow precursors and result in a period of severe pancytopenia of seven to 21 days' duration.

Although the anemia experienced by patients with acute leukemia usually can be corrected readily by erythrocyte transfusions, the absence of other hematopoietic elements leads to more complex medical management problems. Infectious complications directly related to profound granulocytopenia account for nearly 80 per cent of the morbidity and mortality in acute leukemia. The remaining 20 per cent of complications are related primarily to thrombocytopenic bleeding, although other coagulation abnormalities and metabolic derangements occasionally may be encountered.[10]

There are few true emergency indications for chemotherapy in acute leukemia. In general, patients tolerate induction chemotherapy better if they are medically stable with control of infection, life-threatening hemorrhage, or metabolic abnormality. Two indications for immediate chemotherapy are (1) a markedly elevated peripheral blast count (greater than 100,000/cu mm) which carries a significant risk of intracranial leukostasis and hemorrhage, and (2) promyelocytic leukemia with documented coagulation abnormalities. In addition to prompt chemotherapy, a very high blast count may require leukapheresis for control, and the coagulation disorder of promyelocytic leukemia may necessitate anti-coagulation with heparin.[11]

Extremely rapid lysis of leukemic cells may occur during the first few days of chemotherapy, with generation of a large uric acid load and severe uric acid nephropathy. This potentially serious complication can be avoided by starting allopurinol (Zyloprim) prior to definitive chemotherapy.

The primary goals of supportive care for the leukemic patient must be control of infection and

prevention of hemorrhage. If a patient with acute leukemia can be supported adequately through the period of severe marrow hypoplasia until hematopoietic regeneration occurs, the prognosis for a complete remission and months of quality survival is good.

### Blood Component Therapy

Nearly all patients with acute leukemia will develop severe anemia, either at presentation, or during the course of chemotherapy. Since the period of absent erythroid production will be prolonged, delay in correcting the anemia by transfusion generally is of little benefit. Maintaining the hemoglobin at an adequate level will avoid symptoms and prevent undue complications should a significant hemorrhage develop.

Erythrocyte transfusions are administered as packed cells, since the plasma components are unnecessary and may be harmful. Washed packed cells usually are indicated, since erythrocytes prepared in this manner contain fewer antigenic contaminants, and the risk of subsequent transfusion reactions is reduced.

Serious and often life-threatening thrombocytopenia will develop in most leukemic patients, especially in the weeks following induction chemotherapy. Although the potential for increased bleeding exists whenever the platelet count is below 100,000/cu mm., serious spontaneous hemorrhage is very unlikely unless the platelet count is below 20,000/cu mm. When the platelet count approaches the latter value, a regular platelet transfusion program is appropriate and has been shown to reduce hemorrhage greatly.[12]

Initially, pooled, random donor platelets are adequate, and five to 10 units administered every other day frequently will maintain the platelet count above 20,000/cu mm. and prevent hemorrhage. However, with repeated random donor platelet transfusions, the majority of patients eventually will develop allo-immunization to platelet antigens. These patients become refractory to random donor platelets, and achieve no increment in platelet count, even with a large number of transfusions. At this point, only HL-A matched sibling platelets or HL-A "A" matches from a large donor pool will be effective. Fortunately, most patients with acute leukemia do not develop this refractory state until after their first course of induction chemotherapy.[13]

### Control of Infection

Infectious complications are by far the greatest source of morbidity and mortality for patients with acute leukemia. The combination of prolonged granulocytopenia and the immunoincompetence from cytotoxic therapy leads to frequent and, at times, unusual infections. Gram negative bacilli and Staphylococcus aureus are the most commonly identified pathogens; however, with prolonged therapy, fungal, viral and protozoal agents become a real consideration. The source of bacteremia in these compromised patients usually is lung, urinary tract, gastrointestinal tract or skin, although less common sites such as oral or perirectal areas may harbor infection.[14]

Febrile episodes are common in leukemic patients during intensive induction therapy, and frequently the source of infection is not readily apparent. Nevertheless, aggressive management is indicated and, after complete cultures are obtained, the patients should be started on broad-spectrum antibiotic agents. An appropriate antimicrobial regimen should include agents which cover both gram positive and gram negative organisms. A semi-synthetic penicillin or cephalosporin and an aminoglycoside are indicated, often with carbenicillin or ticarcillin for the added synergistic action against certain gram negative bacteria. This combination antibiotic regimen is continued until a definite etiologic agent is identified, at which time the therapy can be modified appropriately. In many cases, a definite source of infection is not located; however, the antibiotics are continued if clinical improvement occurs. Persistent fever despite broad-spectrum antimicrobial therapy may indicate a non-bacterial source of infection.[3]

### Opportunistic Pathogens

The severely granulocytopenic and immunocompromised patient is an ideal host for opportunistic and non-bacterial pathogens. Common offending organisms include fungal species, especially Candida and Aspergillus, as well as viruses, with hepatitis, Cytomegalovirus and Herpes the most prevalent. These and other atypical infectious agents, such as Pneumocystis carinii, must be considered in the compromised leukemic patient remaining febrile after an adequate course of broad-spectrum antibiotics.

Considerable clinical investigation has been directed toward the goal of preventing infection in leukemic patients during therapy. Prophylactic oral antibiotics and protected environments, or laminar-flow facilities, have received the most attention. Several controlled trials have demonstrated some benefit from these procedures with reduced infections and a slightly higher complete remission rate.[15] However, prophylactic oral antibiotics have marked gastrointestinal toxicity,

and protected environments tend to isolate unduly the patient from both medical personnel and relatives. With the exception of investigational protocols, most institutions consider these procedures of minimal value, and their use is not widespread.

Granulocyte transfusions have an important, but limited, role in the management of infected granulocytopenic patients. Recent studies clearly have demonstrated an improved survival rate for granulocytopenic patients with proven bacterial infections when granulocyte transfusions are administered.[16] However, retrospective analysis suggests that patients with impending marrow recovery (within 10 days) do reasonably well without granulocyte transfusions. Conversely, patients with prolonged marrow hypoplasia can achieve significant benefit from a granulocyte transfusion program when documented bacterial infection fails to respond to broad-spectrum antimicrobial agents.

### Outlook

The use of aggressive and severely marrow-suppressive chemotherapy has improved considerably complete remission rates, and brought about prolongation of survival with good quality of life in adult patients with acute leukemia. This benefit has, however, been at the expense of occasional life-threatening toxicities which require the availability of special modalities such as platelet and granulocyte transfusions, and a team of medical personnel familiar with the manifestations of the disease, its treatment and complications. In this setting, the outlook for such patients has improved considerably, and promises to become still better in the future.

*Editor's Note: Here are generic drugs and trade names (in parentheses) to which reference is made in this manuscript: Cytosine arabinoside (Cytosar), Doxorubicin hydrochloride (Adriamycin), Daunorubicin, Vincristine sulfate (Oncovin), Prednisone, 6-thioguanine, Cyclophosphamide (Cytoxan), and Allopurinol (Zyloprim).*

### References


1. Schimpff SC, Aisner J: Empiric antibiotic therapy. *Cancer Treat Rep* 62:673-679, 1978.

2. Schiffer CA: Some aspects of recent advances in the use of blood cell components. *Br J Haematol* 39:289-294, 1978.

3. Freireich EJ, Keating MJ, Gehan EA, *et al.*: Therapy of acute myelogenous leukemia. *Cancer* 42:874-882, 1978.

4. Gale RP: Advances in the treatment of acute myelogenous leukemia. *N Engl J Med* 300:1189-1199, 1979.

5. Glucksberg H, Buckner CD, Fefer A *et al.*: Combination chemotherapy for acute nonlymphoblastic leukemia in adults. *Cancer Chemother Rep* 59:1131-1137, 1975.

6. Peterson BA, Bloomfield CD: Prolonged maintained remissions of adult acute non-lymphocytic leukaemia. *Lancet* 2:158-160, 1977.

7. Fairley GH: Immunotherapy in the management of myelogenous leukemia. *Arch Intern Med* 136:1406-1412, 1976.

8. Thomas ED, Buckner CD, Banaji M *et al.*: One hundred patients with acute leukemia treated by chemotherapy, total body irradiation, and allogeneic marrow transplantation. *Blood* 49:511-533, 1977.

9. Thomas ED, Buckner CD, Clift RA *et al.*: Marrow transplantation for acute nonlymphoblastic leukemia in first remission. *N Engl J Med* 301:597-599, 1979.

10. Levine AS, Deisseroth AB: Recent developments in the supportive therapy of acute myelogenous leukemia. *Cancer* 42:883-894, 1978.

11. Drapkin RL, Gee TS, Dowling MD *et al.*: Prophylactic heparin therapy in acute promyelocytic leukemia. *Cancer* 41:2484-2490, 1978.

12. Freireich EJ: Effectiveness of platelet transfusion in leukemia and aplastic anemia. *Transfusion* 6:50-54, 1966.

13. Lohrmann HP, Bull MI, Decter JA *et al.*: Platelet transfusions from HL-A compatible unrelated donors to alloimmunized patients. *Ann Intern Med* 80:9-14, 1974.

14. Armstrong D, Young LS, Meyer RD *et al.*: Infectious complications of neoplastic disease. *Med Clin N Am* 55:729-745, 1971.

15. Levine AS, Siegel SE, Schreiber AD *et al.*: Protected environments and prophylactic antibiotics: A prospective controlled study of their utility in the therapy of acute leukemia. *N Engl J Med* 288:477-483, 1973.

16. Vogler WR, Winton EF: A controlled study of the efficacy of granulocyte transfusions in patients with neutropenia. *Am J Med* 63:548-555, 1977.

# Primary Choriocarcinoma Of The Lung (A Case Report)

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*This was a case of choriocarcinoma arising from the lung of a male, with the patient undergoing an exploratory right thoracotomy with subsequent lobectomy. The patient had an uneventful recovery.*

PRIMARY extragenital choriocarcinoma in the male is known to occur as a midline tumor in the body, retroperitoneal space, mediastinum or intracranially. In the latter area, pineal body is often the origin; however, there has been one report of two cases of lung origin.[1] The finding of such a tumor during surgical exploration invariably creates consternation and concern. Furthermore, the decision to perform a subsequent bilateral orchiectomy of a palpably normal testes would be difficult indeed.

We studied this case of choriocarcinoma arising from the lung of a male by histological, biochemical assay and repeated physical evaluation. Histologically, there were characteristic findings of choriocarcinoma consisting of irregular, scattered clumps of neoplastic cytotrophoblasts and syncytiotrophoblasts with extensive tumor necrosis and hemorrhage.

### Case Report

This 27-year-old, white male, a glass worker, had no history of using tobacco or alcohol, or traveling abroad. He gave no history of tuberculosis, skin rash or arthralgia. None of his family members died of cancer. In April, 1978, he had his first episode of pain in the right arm, and this was treated with steroids.

In August, 1978, the patient developed sharp pleuritic pain on the right which radiated to the neck and right arm. This was associated with cough and blood-tinged sputum, and had no relation to postural drainage considerations. His physical examination showed a well-developed, adequately-nourished man. There was no evidence of jaundice and no adenopathy. Chest findings did not reveal any abnormal breath sounds. No general abnormal physical findings were noted. The laboratory workup was normal. The chest x-ray revealed a soft tissue density in the right lower lobe associated with pleural reactive changes suggestive of an inflammatory mass. Bronchial aspirate was non-specific and negative for malignant cells.

The patient underwent an exploratory right thoracotomy with subsequent right lobectomy. The microscopic diagnosis was choriocarcinoma with the histologic findings noted above. In addition, an excised mediastinal lymph node was reported as showing histoplasmosis.

After lobectomy, the patient had an uneventful recovery. Other laboratory studies postoperatively were reported as follows: C-T abdominal scan and bilateral pedal lymphangiograms were normal. Brain, bone, liver and spleen scans were normal. Thyroid studies were normal, as were assays for alpha feto-protein (AFB) and colonic embryonic antigen (CEA). Urine did not reveal chorionic gonadotrophin, but serum disclosed positive evidence of Beta HCG.

At present, this man has completed a course of chemotherapy consisting of Vinblastine,

**TABLE**
**Reported Extragenital Choriocarcinoma According to Location of Primary Site[1]**

| | *Mediastinum* | *Retroperitoneum* | *Liver* | *Stomach* | *Urinary bladder* | *Prostate* | *Pineal body* | *Brain* | *Lung* | *Unknown* |
|---|---|---|---|---|---|---|---|---|---|---|
| Fine, *et al.* | 18 | 9 | 1 | 1 | 3 | 1 | 6 | 1 | | |
| Johnson, *et al.* | 1 | 3 | | | | | | | | 1 |
| Utz, *et al.* | 1 | 1 | | | | | | | | |
| Hanaoka, *et al.* | 2 | | | | | | | | | |
| Ozaki, *et al.* | | | | | | | | | | |
| Hayakawa, *et al.* | | | | | | | | | 2 | |
| Total | 22 | 13 | 1 | 1 | 3 | 1 | 6 | 1 | 2 | 1 |

Bleomycin, and Cisplatinum, once a month for four months, and has started maintenance therapy consisting of Velban every four weeks for the next two years. He apparently is doing very well, and there are no notable physical findings. The chorionic gonadotrophic (Beta HCG) is no longer detectable in the patient's serum.

**Discussion**

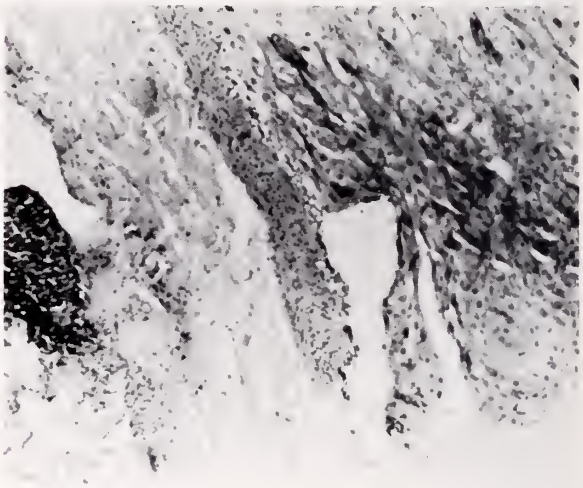
Review of the medical literature notes the usual location of primary extragenital choriocarcinoma to be in the mediastinum, retroperitoneum and pineal body. In this patient we could not locate any midline tumor nor any testicular source.

**Chest x-ray. Soft tissue density at right lower lobe associated with pleural reactive changes.**

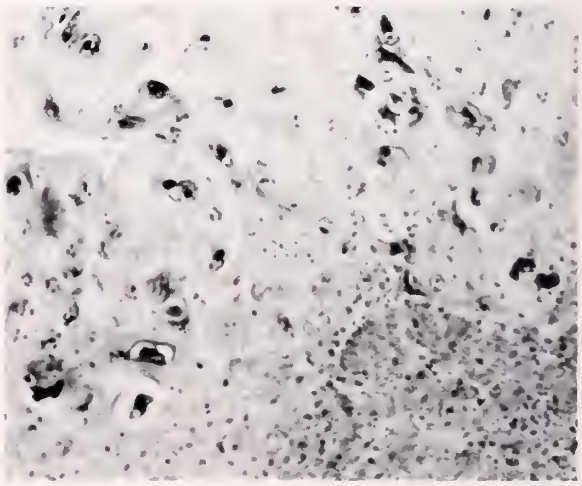
**Cross-section of lung showing the tumor mass.**

In regard to the functional status of the tumors reported, Fine concluded most extragenital choriocarcinoma in the male are associated with evidence of HCG present in all specimens examined regardless of the source being urine, blood or tumor tissue. It is believed the hormone is produced by syncytiotrophoblasts.

The pathogenesis of ectopic germ-cell tumors has not been established. It has been ascribed to a primitive germ-cell theory, a somatic-cell rest theory, or a twin theory. It is believed that the ectopic germ-cell tumors have a tendency to develop along the embryonal or midline axis of the human in the retroperitoneum or mediastinum. The lung is of diverse tissue origin with the blood vessels originating from mesoderm, and the bronchi from the entoderm. It is possible that embryonic totipotential cells may



**Clusters of tumor cells, B.V., lung tissue and aggregate of lymph tissue.**



**Hemorrhage, necrosis, syncytiotrophoblasts and cytotrophoblasts.**

remain dormant in the lungs and subsequently undergo atypical proliferation with trophoblastic differentiation. Another possibility is that these cells may migrate into the lung and remain there. At some later time these cells may develop malignant characteristics.

**Acknowledgement**

We acknowledge the assistance of John W. Durkin, M.D., and Carlos A. Vasquez, M.D., in the preparation of this paper.

**References**

1. Hayakawa K: Primary choriocarcinoma of the lung. Case report of two male subjects. *Acta Pathologica Japonica* 27 (1): 123-135, 1977.

2. Libshitz HI: The pulmonary metastases of choriocarcinoma. *Obstet & Gynecol* 49 (4): 412-416, 1977.

3. Prusty S: Primary mediastinal choriocarcinoma. *Diseases of the Chest* 56 (12): 543-546, 1969.

4. Oberman HA: Malignant germinal neoplasms of the mediastinum. *Cancer* 17 (4): 498-507, 1964.

5. Rostom AY: Unusual, isolated seminoma metastases to the lung. *Brit J of Radiol* 50:523-525, July, 1977.

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Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 ½ by 11 in.) white paper. Wide margins (at least 1 ¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West -Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

*A message from . . .*

*The President*

## THE MANY FACETS OF INSURANCE

THIS month's message will be devoted to the malpractice insurance problem. As most of you probably know, Aetna is submitting a 50.9 per cent average increase in premium. You ask, "How can this be?"

Let's analyze that question and see if we can understand the problem. There are many facets.

(a) Reflectively, are we establishing proper rapport with our patient, or is he some case in Room 5? Do we delegate our history-taking, our physicial exams and even our ordering so the patient doesn't know us and we barely know him?

(b) Medicine used to be fairly simple. Therapeutic capabilities were limited. Most drugs, if not too beneficial, at least were not too toxic. The patient died sooner so he did not recover to be able to sue. Today our treatment results in the "cure" of many who previously died who fail to recognize that less-than-100-per-cent recovery is not poor medicine.

(c) The tone of our society has resulted in a populace that is going to get all it can at the expense of anyone it can get it from. "Sue" is a first thought.

(d) Our failure to defend effectively the suits brought against us results in the loss of the suit and the climate for many new ones. I, for one, am heartily in favor of defending the physician to the hilt and counter-suing any lawyer who institutes a suit where justification does not exist. This is not to say that the truly injured should not be reimbursed, but should there be a suit because the patient's pneumonia lasted four days instead of the average three?

As some malpractice insurance rates increase to over $20,000 in this state and over $35,000 in other states, can we continue to provide affordable medical care?

What are the alternatives?

(a) A government-run malpractice insurance program. What a boondoggle this would be! The injured would not collect, the physician would spend hours in paperwork and the public would pay the bill.

(b) Improved laws to avoid many suits, i.e.: statute of limitation changes, acceptance of panel review, limitation on the dollar amount of settlements, and limitation on the settlement for the cases. When the lawyers have a special club for over-$1,000,000 settlements, one wonders whether the injured party or the lawyer is being reimbursed.

(c) Better policing of our own physicians. Some of this may be needed, but the great majority of physicians are conscientious, careful workers who have always re-educated themselves and work hard to achieve good care. If we throw out the barrel because of a few bad apples, we'll have no fruit to eat. Let's sort out the bad apples.

Your Association is working on alternatives. This year, we must accept the Aetna schedule. By next year we hope to have an alternative or marked reduction in the Aetna fee schedule.

Aetna and the Medical Association have begun development of some new programs and other presentations. The *Risk Cutter* is one of those. A retired judge and panel of lawyers to do early review of the cases is the most recent development in Aetna's activity. This might help defense.

L. Walter Fix M.D.

L. Walter Fix, M. D., *President*

The West Virginia Medical Journal

# Editorials

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**STATES' RIGHTS**

It hardly received the attention accorded "Billygate," but a 91-1 vote in the U. S. Senate recently in support of an amendment by Senator Robert Morgan, Democrat of North Carolina, struck a significant new blow for states' rights and true democracy.

The amendment, backed by Medicine across the land, struck from mental health systems legislation a provision for a federal "bill of rights" for mental patients. By its action, the Senate agreed that each state should review and revise, as necessary, its laws to ensure that mental health patients receive the protection and services they require.

Along with the bill of rights, the Senate measure, before amendment, mandated in-house grievance procedures at all programs or facilities providing mental health services; established a new advocacy program, and provided for a private right of action in federal courts for enforcement of these rights.

Most important, in the view of Senator Morgan, the bill stood as an unwarranted further expansion of federal power. It proposed to override 35 existing state laws on the mental health subject, and to provide a legal tool to coerce states to spend more money on mental health services to the detriment of other activities and services.

Senator Morgan's position certainly was NOT designed to curtail or otherwise interfere with mental health programs, as such. He simply argued that a Senate committee had failed to show ongoing abuses that would make a federal bill of rights necessary.

"Federal laws should not be enacted in the absence of clear need," Senator Morgan insisted in a statement that should be followed much more often in many, many areas of federal activity and maneuvering to make the bureaucracy stronger—but not, in many cases, more effective.

The North Carolina Democrat likewise said that the private right of action permitted in the Senate bill would "simply serve to encourage frivolous law suits and put the federal courts in the business of reviewing medical decisions on a case-by-case basis."

It's also interesting to note that the President's Commission on Mental Health, with a very strong commitment to protection of the rights of disadvantaged individuals, had not endorsed a federal bill of rights.

Rather, it recommended that "each state should be encouraged to adopt a bill . . . " That's where the Senate left the matter, too. And that kind of action, in the face of many instances in which the pendulum has swung the other way, has to be marked up as encouraging.

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**NEW BOOST FOR VE**

It has been a long, tough struggle—but there are signs that the true value of the Voluntary Effort to contain health care costs is gaining significant recognition in government quarters, in particular, where that has not been the case.

The Carter Administration, itself, has asked the nation's hospitals to slow "*voluntarily*" the rate in total expenditures by 1.7 percentage points in 1980, after adjusting for changes in inflation.

Earlier, Lowell H. Steen, M. D., Chairman of the American Medical Association's Board of Trustees, told the annual meeting of the National Governor's Conference in Denver that the VE program helped save consumers about $3 billion in health care costs in 1978-79. He urged more involvement by state governments in the VE effort.

In Washington, as the cornerstone of the new Administration attitude, the Department of Health and Human Services and the Council on Wage and Price Stability set a guideline of 13.4

per cent for increases in hospital expenditures in 1980. The letter noted that the goal was "very close" to the target established by the VE this year. The VE goal, as announced in December, 1979, was for a 1.5-per cent slowdown which would produce about the result the Administration has envisioned.

Paul W. Earle, Executive Director of the VE Program in which the AMA, American Hospital Association, other organizations and their state and local components have participated, said that "we are pleased to see the Administration is acknowledging . . . that costs can be controlled voluntarily, as borne out by the VE's performance in its first two years." He added:

"We also are pleased that HHS now is adjusting figures for the impact of inflation, something we have done from the beginning, to present what we believe to be a more correct picture of the hospital cost situation."

The letters to the VE were signed by HHS Undersecretary Nathan J. Stark and COWPS Chairman Alfred E. Kahn. Readers will remember that the Carter Administration's compulsory hospital cost containment bill was defeated in Congress late in 1979.

In a statement handed the news media, Stark said that "the Administration continues to believe that legislation is necessary . . . We also believe that expenditures can be reduced voluntarily—but only if hospitals and physicians make continued effort to improve the efficiency and probability. We are prepared to work with the industry toward that goal."

In West Virginia, there have been significant steps in a number of community hospital and other settings toward making the VE program effective. Some State Hospital Association survey results show progress in that direction. The leadership of the State Medical Association is committed to cost effectiveness—but with recognition that any such program cannot for a moment sacrifice quality of care.

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**QUALITY ASSURANCE**

An intelligent, well-trained, conscientious physician conducts a thorough evaluation of a patient whose confidence he deserves and gains. Every recommendation made by the physician is meticulously tailored for that specific patient. Diagnostic studies are selected with care and discretion. Expedition, safety, accuracy and economy are major considerations influencing each decision. Every procedure, every treatment, every medication is the best one available in the physician's considered and competent professional opinion.

Radiographic studies are recommended. The patient is hesitant. She has read that x-rays are dangerous. They can cause cancer, leukemia and birth defects.

A computerized axial tomogram of the skull is recommended. The patient is unsure. She has read that they are terribly expensive, frequently unnecessary and that they also involve exposure to x-rays.

Xeromammograms are recommended. The patient is apprehensive. She has read that they cause cancer of the breast, are unreliable and, again, expose her to x-rays.

A minor surgical procedure is advised. The patient refuses. She has read that she should get a second opinion before submitting to any operation.

Diazepam is prescribed for the relief of distressing, frightening and severe symptoms. The patient is alarmed and insists on an alternative. She has read that diazepam is a dangerous, overprescribed drug which will cause serious side effects and addiction.

The physician is frustrated. He cannot use the best available tools to arrive at the best and most accurate diagnosis. He must settle for second or third best. He must forsake the benefits of 30 years of progress in medical diagnosis and therapy. He must prescribe drugs that are less effective, more dangerous and so ancient that his patient hasn't read about them in newspapers or magazines or heard about them on radio or television.

The patient is alarmed, disappointed and angry. Her physician is unreliable, inconsiderate and outrageously expensive. He couldn't find out what was wrong with her, tried to poison her with x-rays, wanted to butcher her with unnecessary surgery and prescribed a pill she'd never heard of. Instead of reassuring her, he just made her feel worse. She congratulates herself for refusing to settle for less than the best health care available. She gives thanks to her divinity for a free press and a vigilant, responsible government for saving her from the clutches of a charlatan. — *Guest editorial by Mark J. Johnson, M. D., Editor-in-Chief, Journal of the Oklahoma State Medical Association, July, 1980.*

# GENERAL NEWS

## Doctor Fix Assumes Presidency Of Medical Association

Dr. L. Walter Fix of Martinsburg, a pathologist who also is in the practice of dermatology, has assumed duties as the new President of the West Virginia State Medical Association.

Doctor Fix was installed as President by Dr. Stephen D. Ward of Wheeling, the retiring President, at the concluding session of the House of Delegates during the 113th Annual Meeting Saturday, August 23, at the Greenbrier in White Sulphur Springs.

The convention began with a meeting of the Council on Wednesday, August 20. The official Medical Association registration totalled 304 and included 273 physicians.

Doctor Ward presided at Wednesday and Saturday sessions of the House. He automatically became Chairman of the Council for the new Association year, succeeding Dr. Robert D. Hess of Clarksburg.

### Other New Officers

Elevated to President Elect from Vice President was Dr. John B. Markey of Charleston, a surgeon, who will be installed as President during the 1981 Annual Meeting, also scheduled at the Greenbrier next August 20-22. (See separate story on House action shortening the 1981 Annual Meeting by one day.)

Dr. Harry Shannon of Parkersburg, a urologist, was elected Vice President, and Dr. George A. Shawkey of Charleston, a pediatrician, was elected Treasurer. Doctor Shawkey succeeded Dr. Kenneth G. MacDonald, Sr., Charleston surgeon who, beginning in 1965, was elected to 15 one-year, uninterrupted terms as Treasurer. (See the House of Delegates resolution praising Doctor MacDonald for his service as Treasurer on Page xvii.)

Dr. Richard E. Flood of Weirton was re-elected to a two-year term as a Delegate to the American Medical Association, with Dr. Harry S. Weeks, Jr., of Wheeling re-elected as Alternate Delegate.

Three new Council members were elected, with five other physicians re-elected to two-year terms.

The three new Councilors are Drs. Michael J. Lewis of St. Marys, Thomas F. Scott of Huntington and Sherman E. Hatfield of Charleston.

Re-elected were Drs. William L. Mossburg of Fairmont, Leo H. T. Bernstein of Martinsburg, Vernon E. Duckwall of Elkins, Carl R. Adkins of Fayetteville, and Arthur E. Levy of Williamson.

Holdover Councilors whose terms will expire in 1981 are Drs. Carlos L. Vasquez of Weirton, Ralph W. Ryan of Morgantown, Dewey F. Bensenhaver of Petersburg, M. V. Kalaycioglu of Shinnston, R. Paul Bennett of Webster Springs, Joseph T. Skaggs of Charleston and T. Keith Edwards of Bluefield.

Under the terms of the Association's Constitution, Doctor Hess, the Council Chairman last year, becomes Councilor-At-Large for 1980-81; and Dr. Joseph A. Smith of Dunbar, the Association President three years removed, will serve as Junior Councilor during the period.

**John B. Markey, M. D.**
**President Elect**

### Amendments Approved

During the two sessions of the House of Delegates, five Constitution and/or By-Laws changes were approved, including a $100 increase, to $250, in the annual dues of the Association's active members, effective with the 1981 calendar and budget year. (See separate story on amendments elsewhere in this issue of *The Journal.*)

The House endorsed plans previously approved by Council to construct a new Association headquarters building in Charleston, with Council, in turn, making a commitment to proceed with the building plans within prudent financial-budgetary capabilities of the Association. House approval of continued planning for building construction under the Council guidelines came during its second session. This was preceded by a presentation of a description of the building—along with a model and floor and lot diagrams—during the first House session on Wednesday. The presentation was made by a representative of Marshall Erdman and Associates, Inc., the firm approved previously by Council to design and build the new facilities.

The House also adopted a resolution directing the Council, working through appropriate committees, to study trends in the cost and quality of medical education in West Virginia, and report back to the House next year; a resolution calling for the Joint Commission on Accreditation of Hospitals to be more selective in its inspection criteria that relate to quality of medical care; and, as noted above, a resolution praising Doctor MacDonald for his years of service as Treasurer of the Association. (Along with the MacDonald resolution, the complete texts of the other two resolutions also appear in this issue of *The Journal.*)

### The President

A native of Buffalo, New York, Doctor Fix received his M. D. degree in 1943 from the University of Buffalo, where he previously completed undergraduate work. In 1943-54, he was on duty as a commissioned officer in the U. S. Navy, with assignments in deep sea diving and submarine medicine along with residency training that brought certification in both clinical and anatomic pathology.

Doctor Fix held a number of teaching positions from 1948 until 1974, ranging from that of Clinical Instructor to Clinical Assistant Professor, at the University of Illinois, George Washington University in Washington, D. C., and Pennsylvania State University at Hershey. He is a Fellow of the American Society of Clinical Pathologists and the College of American Pathologists, and a member of dermatological societies in West Virginia and Baltimore, Maryland.

**Some of the new or re-elected officers and Councilors of the State Medical Association are shown during the 113th Annual Meeting of the Association August 20-23 at the Greenbrier in White Sulphur Springs. Seated, from left, are Drs. Harry Shannon, Parkersburg, Vice President; John B. Markey, Charleston, President Elect; L. Walter Fix, Martinsburg, President; Ralph W. Ryan, Morgantown (holdover Councilor), and Vernon E. Duckwall, Elkins, re-elected Councilor; second row, from left, Drs. Sherman E. Hatfield, Charleston, new Councilor; Arthur E. Levy, Williamson, re-elected Councilor; Harry S. Weeks, Jr., Wheeling, re-elected as an AMA Alternate Delegate; Leo H. T. Bernstein, Martinsburg, re-elected Councilor, and George A. Shawkey, Charleston, Treasurer.**

Doctor Fix was President of the West Virginia Association of Pathologists in 1968-69, and Vice President of the Eastern Panhandle Medical Society in 1964-65. He was a member of the State Medical Association's Council from 1972 until 1978, when he was elected as the Association's Vice President.

Active in Lutheran church, cancer society and Red Cross activities, Doctor Fix currently is pathologist in an eight-county Eastern Panhandle area for the State Medical Examiner's Office; Chairman of the Berkeley County Public Service Sewer District, and a member of the Shepherd College Foundation.

He is married to the former Catherine Caryl of Rochester, New York, and they are the parents of five daughters.

#### The President Elect

Doctor Markey was elected Vice President last year after serving on the Association's Council for the previous two years. He is Chief of Staff at Charleston Area Medical Center and a former President of the Kanawha Medical Society.

A native of Sharples, in Logan County, Doctor Markey has A. B. and B. S. degrees from West Virginia University, and his M. D. degree from the Medical College of Virginia. He has been an Association member since 1958, after finishing an internship and residency in 1954-58 at Charleston General Hospital.

#### The Vice President

Doctor Shannon, who was elected to a two-year term on the Association's Council in 1978, is practicing urology with Parkersburg Medical Associates, and is Vice President of the Staff at Camden Clark Memorial Hospital in Parkersburg.

A native of Star City, Arkansas, he was graduated from Hendrix College in Conway, Arkansas, and received his M. D. degree in 1968 from Tulane University School of Medicine. He is a Diplomate of the American Board of Urology and a Fellow of the American College of Surgeons.

During the past year, he served as Chairman of the Association's AMA-ERF Committee and a member of the Association's Legislative and Public Service committees. He also served on the Association's Ad Hoc Committee on Long Range Planning and Ad Hoc Committee on the Medical Practice Act.

#### AMA-ERF Presentations

Doctor Ward presented to Dr. John E. Jones, Dean of the West Virginia University School of Medicine, a check for $14,475.33; and to Dr. Robert W. Coon, Dean of the Marshall University School of Medicine, a check for $9,808.35, during the first House Session. The checks represented an annual contribution by West Virginia physicians and the Auxiliary to the medical schools through the Education and Research Foundation of the AMA (AMA-ERF). Also present was Mrs. D. Sheffer Clark of Huntington, then President of the Auxiliary to the State Medical Association.

Dr. William R. Barclay of Chicago, Editor of the Journal of the American Medical Association (JAMA), addressed physicians during opening exercises preceding the first general scientific session on Thursday morning.

## Delegates Approve Constitution, By-Laws Amendments

The Medical Association's House of Delegates approved the following Constitution and/or By-Laws changes during its annual sessions in August at the Greenbrier in White Sulphur Springs:

—A $100 increase, to $250, in the annual dues of the Association's active members, effective with the 1981 calendar and budget year.

—Establishment as standing committees (they have existed in an ad hoc status) of the Committee on Physician Services and the Committee on Long Range Planning; and designation of general responsibilities for those committees.

—Effecting a technical correction providing for by-laws reference to the new West Virginia Board of Medicine as the successor to the old Medical Licensing Board of West Virginia.

—Provision, beginning in 1981, for submission by the Committee on Nominations of at least two names for the Association offices of Vice President, Treasurer, American Medical Association Delegate and AMA Alternate.

—Provision, also to be effective in 1981 elections, for additional Council representation from Council Districts with 200 and more State Medical Association members—action which culminated three years of consideration by the House of this matter.

The Committee on Physician Services will be charged with developing research and/or service plans and programs—consistent and in concert with law, regulations or other appropriate mechanisms—for the identification, counseling, treatment, education and/or rehabilitation of a physician suffering impairment for any reason.

# Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb. Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal).

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

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| Oct. 2 | Morgantown | Annual Pediatric Teaching Day |
| Oct. 3-4 | Morgantown | W. Va. Chapter, American College of Surgeons |
| Oct. 11-13 | Charleston | Biomechanics in the Practice of Orthopedic Surgery |
| Oct. 17 | Morgantown | Nutrition and Metabolism Seminar |
| Oct. 21-22 | Charleston | Nutrition: The Childbearing Years |
| Nov. 7 | Charleston | The Arthur B. Hodges Center Symposium on Diabetes and Aging |
| Nov. 21-22 | Morgantown | 1st Annual Sports Medicine Symposium |

## Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

*Buckhannon*, Upshur-Buckhannon Middle School, 3rd Thursday, 7-9 P. M. — October 16, "Medico-Legal Aspects of Health Delivery," Richard D. Lindsay, M. D., J. D.; November 20, "Trauma to the Head," A. L. Poffenbarger, M. D.

*Cabin Creek*, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M.—October 8, "Lower Back Pain," Tony C. Majestro, M. D.; November 12, "Fertility and Sterility: Management and Treatment," John T. Chambers, M. D.

*Oak Hill*, White Oak Country Club, 4th Tuesday, 7-9 P.M.—October 28, "Interactive Relationship of Commonly Prescribed Drugs," Carl J. Malanga, Ph.D.

*Welch*, Stevens Clinic Hospital, 3rd Wednesday, 11 A. M.-1 P. M.—October 15, "Gastroenterology," Brittain McJunkin, M. D.

*Whitesville*, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M.—October 22, "Diabetes Mellitus," Douglas L. Jones, M. D.; November 19,* "Hypertension: Diagnosis and Treatment," T. Ray Perrine, M. D.

*Williamson*, Appalachian Power Company Auditorium, 1st Thursday, 6-8 P. M.—October 2, "Interactive Relationship of Commonly Prescribed Drugs," Terry Prettyman, R. Ph.

*Scheduled on third Wednesday because of Thanksgiving.

## Sections And Societies Choose Officers For New Year

Here are officers elected or re-elected by sections and specialty societies during meetings at the Greenbrier during the State Medical Association's convention in August:

Section on Orthopedic Surgery: Dr. Bernard M. Swope, Welch, President; Dr. Larry Jack Stemple, Morgantown, Vice President, and Dr. Arthur A. Abplanalp, Charleston, Secretary-Treasurer.

West Virginia Radiological Society: Dr. Arthur E. Levy, Williamson, President; Dr. John W. Kennard, Wheeling, Vice President, and Dr. Orlando F. Gabriele, Morgantown, Secretary-Treasurer.

Section on Urology: Dr. Stanley J. Kandzari, Morgantown, President, and Dr. John Belis, also of Morgantown, Secretary-Treasurer.

West Virginia Chapter, American College of Emergency Physicians: Dr. H. A. Nabers, Jr., Parkersburg, President; Dr. Vincent J. Mazzella, Parkersburg, Vice President; Dr. E. B. Santos, Huntington, President Elect, and Dr. Roger L. Frome, Glen Dale, Secretary-Treasurer.

## Neurosurgeon, HMO Medical Advisor On Program

A Morgantown neurosurgeon and the Medical Advisor of the Charleston Health Maintenance Organization are among additional speakers being announced by the Program Committee for the 14th Mid-Winter Clinical Conference.

G. Robert Nugent, M. D.

Frederick M. Cooley, M. D.

The continuing education event will be held next January 23-25 in Charleston at the Holiday Inn Charleston House.

Sponsors are the State Medical Association and the Marshall University and West Virginia University Schools of Medicine.

G. Robert Nugent, M. D., Professor and Chairman, Department of Neurosurgery, WVU School of Medicine, will speak during the Saturday afternoon, January 24, session, taking the "pro" position on the topic, "TIA: Is Surgery Indicated?"

He will be one of four speakers during the Saturday afternoon session on "Controversies in Medicine." The other controversy covered will involve the treatment of obesity, with one speaker taking the behavioral modification approach, and another, the surgical treatment approach. As announced previously, Dr. Mohammed M. Boustany of Charleston will discuss the surgical treatment.

Doctor Cooley will be one of up to six panelists examining individual practice association (IPAs) and health maintenance organizations (HMOs) during the concluding Sunday morning, January 25, session.

The conference will begin Friday afternoon with talks on fiberoptics and microsurgery. James W. Manier, M. D., of Morgantown, as announced previously, will speak on colonoscopy for one of the talks on fiberoptics.

A physicians' session presented by the West Virginia Medical Institute, Inc., and a concurrent public session on allergies are scheduled Friday evening.

Presentations on drug interactions and antibiotic update are scheduled Saturday morning. The speaker for the Friday night public session also will present a paper on allergies for physicians Saturday morning.

"Controversies in Medicine," as noted, will constitute the Saturday afternoon session, followed by the Sunday morning session on IPAs and HMOs.

Doctor Nugent, a native of Yonkers, New York, held teaching posts at Duke University and the University of Cincinnati before coming to WVU in 1964.

### M. D. from University of Cincinnati

He was graduated from Kenyon College in Gambier, Ohio, received his M. D. degree in 1953 from the University of Cincinnati, and completed his internship and residency in neurosurgery at Duke University.

The author or co-author of some 48 articles, Doctor Nugent is certified by the American Board of Neurological Surgery.

Doctor Cooley, a native of Charleston, also serves as Medical Director, West Virginia Office of Emergency Medical Services; Center Physician, Charleston Job Corps Center, and Consultant, West Virginia Department of Health.

He is board certified in Family Practice, and is Clinical Associate Professor, WVU School of Medicine. He received his M. D. degree in 1962 from WVU and interned at Charleston Memorial Hospital.

The program meets the criteria for 13 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association, and also is expected to be approved for Prescribed Credit by the American Academy of Family Physicians.

A registration fee of $40 will be charged all registrants except nurses, medical students, interns and residents. For advance registration, make checks payable to West Virginia State

Medical Association, and mail to the Association at P. O. Box 1031, Charleston 25324.

Serving on the Program Committee are Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston, Co-Chairmen; and Drs. William O. McMillan, Jr., Charleston; Maurice A. Mufson, Huntington; Robert L. Smith, Morgantown, and C. Carl Tully, South Charleston.

The Committee also is receiving assistance from WVU Charleston Division staff members J. Zeb. Wright, Ph. D., Coordinator of Continuing Education, Department of Community Medicine, and Sharon A. Hall, Conference Coordinator.

## MU Critical Care Conference Scheduled In November

Trauma and sepsis in the ICU will be explored at the Second Annual Rowland H. Burns, M. D., Memorial Critical Care Conference to be held by the Marshall University School of Medicine Saturday, November 8. The site will be the MU Memorial Student Center in Huntington.

The one-day conference offers six hours of Category 1 continuing medical education credit for the Physician's Recognition Award of the American Medical Association and six prescribed hours of credit from the American Academy of Family Physicians.

Serving as guest faculty will be James D. Heckman, M. D., Associate Professor of Surgery, Orthopedics Division, University of Texas School of Medicine, and John Sheagren, M. D., Professor of Medicine at the University of Michigan. Doctor Sheagren also is Medical Services Chief for the VA Medical Center at Ann Arbor.

MU School of Medicine faculty members serving as conference lecturers include: James Coil, M. D., and Lorraine Rubis, M. D., Associate Professors of Surgery; William C. Graham III, M. D., and Lee Van Voris, M. D., Assistant Professors of Medicine; Charles E. Turner, M. D., Clinical Associate Professor of Medicine, and William S. Sheils, M. D., Clinical Assistant Professor of Medicine.

Doctor Turner, a gastroenterologist, and Doctor Sheils, a cardiologist, are members of the Huntington Internal Medicine Group in which the late Doctor Burns was a senior member.

"The Burns Critical Care Conference was established through the MU Foundation by colleagues and friends of the late heart/lung specialist to provide CME programs on vital critical care topics to benefit all health care professionals," explained Doctor Turner, conference planning Chairman.

Discussions will cover the areas of pre-hospital care; post-traumatic gastrointestinal problems; musculoskeletal problem management; evaluation/management of thoracic injuries in multitrauma patients; seriously ill, septic patient approach; trauma patient infection and multiple-antibiotic usage in septic patients.

A complimentary spouses program which includes a tour of the Huntington Galleries and lunch has been planned, leaving the afternoon free for leisure activities.

Advance registration is encouraged, and early registration fees will be $40 for physicians; $20 for residents, nurses and other health care personnel, and $7.50 for medical students. Advance registrations should be received by October 31.

Fees paid at the door will be $45 and $25; however, the medical student registration fee will not increase.

For additional information or to register write: Charles W. Jones, Ph.D., CME Director, School of Medicine, Marshall University, Huntington 25701, or call his office (304) 696-4822.

## Sports Champions Crowned At Annual Meeting

Dr. Joseph T. Mallamo, Fairmont surgeon, and Dr. George A. Curry, Morgantown internist, were co-winners of the Medical Golf Tournament held during the State Medical Association's Annual Meeting at the Greenbrier in August.

Each had an 18-hole low gross score of 78.

Winning the women's golf competition was Mrs. Arthur A. (Faye) Abplanalp of Charleston.

Winners of the men's doubles tennis competition were Drs. E. Noel McIntosh and George W. Weinstein, both of Morgantown, with the team of Drs. Albert G. Capinpin, Charleston, and R. John C. Pearson, Morgantown, in the runnerup role.

Doctor McIntosh, who said it was his "first start" in that particular kind of competition, also won the first distance run held as a part of the convention's extra-curricular activities.

Dr. Harvey D. Reisenweber of Martinsburg, the organizer of the run over a course of between two and three miles on the Greenbrier grounds, was second. There were 15 physicians and family members in the initial field.

In women's tennis play, Mrs. Thomas J. Janicki and Mrs. Carl J. Roncaglione, both of Charleston, made up the winning doubles team.

## Standing and Special Committees Appointed By Doctor Fix

Here is a list of the standing, special and ad hoc committees which have been named by Dr. L. Walter Fix of Martinsburg, President of the West Virginia State Medical Association, to function during his one-year term of office.

### Aging

Lee B. Todd, Quinwood, Chairman; Myer Bogarad, Weirton; Richard Hamilton, St. Marys; Josefina Q. Marcelo, Berkeley Springs; Sam Milchin, Bluefield, Virginia; Ralph H. Nestmann, Charleston; William J. Steger, Wheeling, and Pat A. Tuckwiller, Charleston.

### Cancer

David B. Gray, Charleston, Chairman; Alvin L. Watne, Morgantown, Vice Chairman; John J. Battaglino, Jr., Wheeling; Walter B. Bice, Jr., Parkersburg; Timothy K. Bowers, Martinsburg; James P. Carey, Huntington; Cordell A. de la Pena, Clarksburg; S. William Goff, Parkersburg; Arthur E. Levy, Williamson; Catalino B. Mendoza, Jr., Clarksburg; Hu C. Myers, Philippi; Robert W. Neilson, Bluefield; Jess S. Renedo, Wheeling; John W. Trenton, Kingwood, and Carlos A. Vasquez, Wheeling.

### Constitution and By-Laws

Stephen D. Ward, Wheeling, Chairman; Richard E. Flood, Weirton; Carl B. Hall, Charleston; Robert D. Hess, Clarksburg; J. C. Huffman, Buckhannon; Richard V. Lynch, Jr., Morgantown; John J. Mahood, Bluefield; Joseph B. Reed, Buckhannon; Joseph T. Skaggs, Charleston, and Harry S. Weeks, Jr., Wheeling.

### Insurance

Lyle D. Vincent, Parkersburg, Chairman; William R. Barton, Wheeling; James L. Bryant, Clarksburg; John T. Chambers, Charleston; David V. Cole, Point Pleasant; R. U. Drinkard, Wheeling; H. Summers Harrison, Morgantown; James A. Heckman and C. A. Hoffman, Huntington; Edward Jackson, St. Albans; James W. Lane, Kenneth G. MacDonald, Sr., and A. Thomas McCoy, Charleston; Buford W. McNeer, Hinton; C. Vincent Townsend, Martinsburg, and John F. I. Zeedick, Charleston.

### Sub-Committee on Investments and Trust

C. A. Hoffman, Chairman; Kenneth G. MacDonald, Sr. (1981); James L. Bryant (1982); John T. Chambers (1983), and A. Thomas McCoy (1984).

### Ad Hoc Committee on Professional Liability

Jack Leckie, Huntington, Chairman; John T. Chambers, Charleston; William E. Gilmore, Parkersburg; Kenneth G. MacDonald, Sr., Charleston, and Worthy W. McKinney, Beckley.

### Interprofessional Relations

William E. Gilmore, Parkersburg, Chairman.

**Dr. Robert B. Hunter (center), President of the American Medical Association, is shown in the left photo prior to addressing the first session of the House of Delegates during the State Medical Association's 113th Annual Meeting August 20-23 at the Greenbrier in White Sulphur Springs. With him are Drs. Stephen D. Ward, left, Wheeling, then State Medical Association President, and Frank J. Holroyd, Princeton, an Association Delegate to the AMA. On the right, Doctor Ward presents to Dr. Robert W. Coon, Dean of the Marshall University School of Medicine, a check for $9,808.35 during the first House session. The check represents an annual contribution by West Virginia physicians and the Auxiliary to the medical school through the Education and Research Foundation of the AMA (AMA-ERF). Looking on are Mrs. D. Sheffer Clark of Huntington, then President of the State Auxiliary, and Dr. John E. Jones, Dean of the West Virginia University School of Medicine, who was presented a check for $14,475.33.**

**Sub-Committees**

*Medico-Legal*: John F. I. Zeedick, Charleston, Chairman; Charles W. Merritt, Beckley; John F. Otto, Huntington, and Paul H. Revercomb, Charleston.

*Medicine and Religion*: Joe N. Jarrett, Oak Hill, Chairman; Marshall J. Carper, South Charleston, and William L. Neal, Huntington.

*Medicine and Pharmacy*: L. Dale Simmons, Clarksburg, Chairman; Donald E. Cunningham, St. Albans; John L. Fullmer, Morgantown, and Donald S. Robinson, Huntington.

*Medical-Dental Liaison*: John A. B. Holt, Charleston, Chairman; Alberto G. Capinpin, Charleston; Gene Lee Hackleman, Huntington, and David A. Kappel, Wheeling.

*Nurses Liaison*: Richard E. Flood, Weirton, Chairman; Billie M. Atkinson, Parkersburg; Jean P. Cavender, Charleston; Asel P. Hatfield, Harrisville, and Jack J. Stark, Belpre, Ohio.

**Legislative**

Frank J. Holroyd, Princeton, and Stephen D. Ward, Wheeling, Co-Chairmen; W. Alva Deardorff, South Charleston, Vice Chairman; Carl R. Adkins, Fayetteville; David F. Bell, Jr., Bluefield; R. Paul Bennett, Webster Springs; A. Paul Brooks, North Parkersburg; William H. Carter, Williamson; John T. Chambers, Charleston; John S. Cook, Welch; Del Roy R. Davis, Kingwood; Vernon E. Duckwall, Elkins; Roy A. Edwards, Jr., Huntington; T. Keith Edwards, Bluefield; A. C. Esposito, Huntington; Richard E. Flood, Weirton; George Gevas, Parkersburg; Paul E. Gordon, Clarksburg; N. B. Groves, Martinsburg; Carl B. Hall and John M. Hartman, Charleston; Robert D. Hess, Clarksburg; John A. B. Holt, Charleston; J. C. Huffman, Buckhannon; M. V. Kalaycioglu, Shinnston; Jack Leckie, Huntington; Milton J. Lilly, Jr., and A. Thomas McCoy, Charleston; Paul L. McCuskey, Parkersburg; Worthy W. McKinney,

# Review A Book

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*Basic Histology, 3rd Edition*, by Luis C. Junqueira, M. D.; and Jose Carneiro, M. D. 504 pages. Price $15.50. Lange Medical Publications, Los Altos, California 94022. 1980.

*Basic & Clincal Immunology, 3rd Edition*, by H. Hugh Fudenberg, M. D.; Daniel P. Stites, M. D.; Joseph L. Caldwell, M. D., and J. Vivian Wells, M. D. 782 pages. Price $17.50. Lange Medical Publications, Los Altos, California 94022. 1980.

*Review of Medical Physiology, 9th Edition*, by William F. Ganong, M. D. 618 pages. Price $14. Lange Medical Publications, Los Altos, California 94022. 1979.

**Dr. William R. Barclay (center), Chicago, Editor of the Journal of the American Medical Association, who delivered the Thomas L. Harris Address prior to the first general session of the State Medical Association's Annual Meeting in August, is shown in the left photo. With him are Drs. Martin D. Reiter (left), Wheeling, Chairman of the 1980 Program Committee, and Joe N. Jarrett, Oak Hill, who delivered the invocation for the opening exercises preceding the first session. Shown in the center photo are two of the speakers for the first session, Drs. John A. Kenney, Jr. (left), Washington, D. C., and Joseph W. Burnett (right), Baltimore, with Dr. William A. Welton, Morgantown, moderator. The third speaker for the first session, Dr. Donald S. Robinson, Huntington, is on the right.**

Beckley; Harvey A. Martin, White Sulphur Springs; Charles W. Merritt, Beckley; Houston B. Moore, Lewisburg; Joseph D. Romino, Fairmont; Carl J. Roncaglione, South Charleston; Harry Shannon, Parkersburg; Joseph T. Skaggs, James T. Smith and Pat A. Tuckwiller, Charleston; Lyle D. Vincent, Parkersburg; Harry S. Weeks, Jr., and Robert R. Weiler, Wheeling; J. Hugh Wiley, Morgantown, and Moseley H. Winkler, Charleston.

#### Maternal and Perinatal Fetal Welfare

Sammuel J. Bracken, Wheeling, Chairman; Larry D. Curnutte, Charleston; Robert D. Crooks, Parkersburg; Frederick H. Dobbs, Charleston; T. Keith Edwards, Bluefield; Fernando G. Giustini, Wheeling; W. Gene Klingberg, Morgantown; George S. Kosar, Weirton; A. Robert Marks, Clarksburg; William A. Neal, Morgantown; Thomas G. Potterfield, Charleston; Robert P. Pulliam, Beckley; F. H. Ross, Jr., Martinsburg; Narinder N. Sehgal and George A. Shawkey, Charleston, and H. Alexander Wanger, Martinsburg.

#### Sub-Committee on Perinatal Fetal Welfare

W. Gene Klingberg, Morgantown, Chairman; Robert D. Crooks, Parkersburg; A. Robert Marks, Clarksburg, and Thomas G. Potterfield and George A. Shawkey, Charleston.

#### Medical Aspects of Sports

K. Douglas Bowers, Jr., Morgantown, Chairman; Dewey Bensenhaver, Petersburg; Colin M. Craythorne, Huntington; Clemente Diaz, Richwood; Thomas O. Dotson, White Sulphur Springs; John P. Griffith, Jr., and Robert E. Jones, Wheeling; James S. Kessel, Ripley; Charles A. Lefebure, Clarksburg; Tony C. Majestro, Charleston; Harvey D. Reisenweber, Martinsburg; Carl J. Roncaglione, South Charleston; George W. Rose, Clarksburg; James K. Sexton, Charleston; Clifford Sperow and William D. Strauch, Martinsburg; Robert R. Weiler, Wheeling, and Robert S. Wilson, Clarksburg.

#### Medical Economics

Robert L. Ghiz, Charleston, Chairman, and Harry S. Weeks, Jr., Wheeling, Vice Chairman.

#### Sub-Committees

*Federal Medical Activities*: W. Alva Deardorff, South Charleston, Chairman; Grover C. Hedrick, Jr., Beckley; J. L. Mangus, Charleston; Richard John Pearson, Morgantown; Harry B. Scott, Martinsburg; James F. Slaughter, Dunbar, and Philip M. Sprinkle, Morgantown.

*State Workmen's Compensation*: Carl J. Roncaglione, South Charleston, Chairman; Marshall J. Carper, South Charleston; James V. Gainer, Jr., Clarksburg; Sherman E. Hatfield, Charleston; Ralph J. Holloway, South Charleston; Lawrance S. Miller, Morgantown; Milton E. Nugent, Wheeling; Roy R. Raub, Princeton; M. D. Reiter, Wheeling, and Ralph S. Smith, Jr., Charleston.

*Blue Cross-Blue Shield Third Party*: J. D. H. Wilson, Clarksburg, Chairman; Robert W. Bess, Jr., Piedmont; Albert C. Esposito, Huntington; Ernest G. Guy, Philippi; Milton J. Lilly, Jr., Charleston; John F. Otto, Huntington; Richard C. Rashid, South Charleston, and Edward C. Voss, Wheeling.

*Public Welfare—Joint Conference Committee*: John B. Markey, Charleston, Chairman; Charles E. Andrews, Morgantown; Clemente Diaz, Richwood; Harold P. Dinsmore, Ronceverte; Richard E. Flood, Weirton; F. A. Hamilton, Jr., Martinsburg; Lewis N. Fox, MacArthur; William H. Harriman Jr., Terra Alta; Kenneth B. Lauren, West Union; Seigle W. Parks, Charleston; Hiram Sizemore, Jr., Shepherdstown; L. Mildred Williams, Charles Town.

*United Mine Workers Welfare and Retirement Fund*: Thomas P. Long, Man, Chairman; Arthur A. Carr, Welch; Ray A. Harron, Bridgeport; John M. Hartman, Charleston; John William Kennard, Wheeling; Elbert Leon Linger and Lawrence B. Thrush, Clarksburg, and Lee B. Todd, Quinwood.

*Vocational Rehabilitation*: Robert L. Ghiz, Charleston, Chairman; Carrel M. Caudill, Charleston; Terrell Coffield, New Martinsville; Creel S. Cornwell, Jr., Clarksburg; Colin M. Craythorne, Huntington; Charles M. Davis, Jr., Morgantown; Charles R. Loar, Parkersburg; Robert W. Lowe, Huntington; Tony C. Majestro, Charleston; Joseph T. Mallamo, Fairmont; Ralph S. Smith, Jr., Charleston, and William H. Wanger and R. James Yates, Beckley.

#### Medical Education and Hospitals

William O. McMillan, Jr., Charleston, Chairman; Charles E. Andrews, Morgantown; Leo H. T. Bernstein, Martinsburg; Thomas J. Beynon, Weirton; William H. Carter, Charleston; T. H. Chang, Clarksburg; John S. Cook, Welch; Robert W. Coon, Huntington; Creel S. Cornwell, Jr., Clarksburg; Jack E. Cox, Fairmont; C. Richard Daniel, Beckley; Del Roy R. Davis, Kingwood; Thomas O. Dotson, White Sulphur Springs; William J. Echols, Huntington; T. Keith Edwards, Bluefield; Albert C. Esposito, Hunting-

ton; Alfred D. Ghaphery and George M. Kellas, Wheeling; George S. Kosar, Weirton; Mary Lou L. Lewis, Charleston; David Z. Morgan, Morgantown; Maurice A. Mufson and Dennis S. O'Connor, Huntington; R. Wade Ortel, Wheeling; John F. Otto, Huntington; Herbert H. Pomerance, Charleston; Jeffrey S. Schultz, Wheeling; L. Dale Simmons, Clarksburg; Robert L. Smith, Morgantown; Michael M. Stump, Elkins; Charles W. Thacker, Parkersburg; John W. Traubert, Morgantown; C. Carl Tully, South Charleston; Charles E. Turner, Huntington, and R. James Yates, Beckley.

**Medical Emergencies and Civil Defense**

Jack Leckie, Huntington, Chairman; Adla Adi, Charleston; John V. Brannon, Bridgeport; Frederick M. Cooley, Charleston; William D. Crigger, South Charleston; Thomas O. Dickey, Wheeling; Henry R. Glass, Jr., Charleston; James C. Hazlett, Wheeling; Jules F. Langlet, Charles Town; Walter H. Moran, Jr., Morgantown; Jack R. Page, Charleston, and William E. Walker, Huntington.

**Medical Scholarships**

John Mark Moore, Wheeling, Chairman; R. L. Chamberlain, Buckhannon; Marshall J. Carper, South Charleston; Robert D. Hess, Clarksburg; Thomas J. Holbrook, Huntington; James T. Hughes, Ripley; Kenneth G. MacDonald, Sr., Charleston; William L. Mossburg, Fairmont, and Clark K. Sleeth, Morgantown.

**Mental Health**

Roy A. Edwards, Jr. Huntington, Chairman; Greenbrier Almond, Buckhannon; Mildred Mitchell-Bateman, Huntington; Donald C. Carter, Morgantown; Ray S. Greco, Weirton; David P. Hill, Wheeling; Florence K. Hoback, Huntington; James Paul Markham, Clarksburg; Wilbur Z. Sine, Morgantown; Larry C. Smith, Huntington, and Ralph S. Smith, Jr., and Charles C. Weise, Charleston.

**Military Medical Affairs**

Buford W. McNeer, Hinton, Chairman; Bert Bradford, Jr., Charleston; David R. Hess, Bridgeport, and James K. Sexton, Charleston.

**Annual Meeting Program**

T. Keith Edwards, Bluefield, Chairman; Jerome C. Arnett, Jr., Elkins; Ruth C. Harris, Huntington; Stanley J. Kandzari, Morgantown; John B. Markey, Charleston, and Harvey D. Reisenweber, Martinsburg.

**Public Service**

Stephen D. Ward, Wheeling, Chairman; C. R. Davisson, Weston; Leonard M. Eckmann, South Charleston; G. Thomas Evans, Fairmont; Louis W. Groves, Jr., Richwood; N. B. Groves, Martinsburg; L. J. Pace, Princeton; Harry Shannon, Parkersburg; Jack J. Stark, Belpre, Ohio, and A. J. Weaver, Clarksburg.

**Resolutions**

Richard E. Flood, Weirton, Chairman; William E. Gilmore, Parkersburg; Winfield C. John, Huntington; John J. Mahood, Bluefield; Worthy W. McKinney, Beckley; Joseph A. Smith, Dunbar, and Harry S. Weeks, Jr., Wheeling.

**Rural Health**

N. Allen Dyer, Princeton, Chairman; Harold D. Almond, Buckhannon; Ralph H. Boone,

**Two of the speakers for the second general session of the State Medical Association's Annual Meeting in August are shown in the left photo. They are Drs. Rogers J. Smith (left), Portland, Oregon, and Patrick R. Staunton, Park Ridge, Illinois. With them is Dr. Mildred Mitchell-Bateman, Huntington, who moderated. In the center photo, Dr. William B. Svoboda, Morgantown, the third speaker for the second session, puts references for his talk on the chalkboard. On the right, Dr. Clinton S. McGill (right), Portland, Oregon, is shown with Dr. Harry S. Weeks, Jr., Wheeling, moderator for the third general session. Doctor McGill, a member of the AMA Speakers' Bureau, was a speaker for the third general session.**

Sistersville; David R. Chapman, Keyser; Lemoyne Coffield, New Martinsville; Robert W. Coplin, Elizabeth; Earl L. Fisher, Gassaway; Asel P. Hatfield, Harrisville; Joe N. Jarrett, Oak Hill; Charles T. Lively, Weston, and Charles J. Sites, Franklin.

**School Health**

Thomas L. Thomas, Wheeling, Chairman; R. J. Bailey, Parkersburg; Hugh M. Brown, Clarksburg; Thomas G. Folsom, Barboursville; Peter A. Haley, Charleston; Grover C. Hedrick, Jr., Beckley; Mary Jordan, Fairmont; Edward Shupala, Parkersburg, and Eli J. Weller, Weirton.

**Tuberculosis**

Harry K. Tweel, Huntington, Chairman; Charles E. Andrews, Morgantown; Robert M. Biddle, Parkersburg; Dominic J. Gaziano and Ralph H. Nestmann, Charleston; Robert J. Reed III, Wheeling; James H. Walker, Charleston, and Herbert E. Warden, Morgantown.

**Venereal Disease**

Page H. Seekford, Charleston, Chairman; N. H. Dyer, Princeton; Frank M. Peck, Huntington; David S. Pugh, Chester; Thomas L. Thomas, Wheeling; Lyle D. Vincent, Parkersburg; K. William Waterson, Wheeling, and Isaiah A. Wiles, Morgantown.

**AMA-ERF**

Harry Shannon, Parkersburg, Chairman; Russell R. Brandon, Chesapeake, Ohio; Robert W. Coon, Huntington; John E. Echols, Richwood; John H. Giles, Parkersburg; Joseph Gilman, Clarksburg; Joe N. Jarrett, Oak Hill; M. Bruce Martin, Huntington; William T. Lawson, Fairmont; Buford W. McNeer, Hinton; David Z. Morgan, Morgantown; Donald R. Roberts, Elkins; George A. Shawkey, Charleston; John W. Trenton, Kingwood, and E. Andrew Zepp, Martinsburg.

**WVU Medical Liaison**

James L. Bryant, Clarksburg, Chairman; Kenneth J. Allen, Glen Dale; William E. Barnes, Parkersburg; Dewey F. Bensenhaver, Petersburg; W. T. Booher, Jr., Wellsburg; K. Douglas Bowers, Jr., Morgantown; A. Kyle Bush, Philippi; James William Campbell, Wheeling; Terrell Coffield, New Martinsville; C. Richard Daniel, Beckley; Del Roy R. Davis, Kingwood; G. Thomas Evans, Fairmont; John M. Grubb, Point Pleasant; Carl B. Hall, Charleston; J. C. Huffman, Buckhannon; Joe N. Jarrett, Oak Hill; Kenneth G. MacDonald, Sr., Charleston; Ross E. Newman, Mullens; Russell A. Salton, Williamson; Robert G. Shirey, Lewisburg, and John W. Traubert, Herbert E. Warden and J. Hugh Wiley, Morgantown.

**Marshall Medical Liaison**

Winfield C. John, Huntington, Chairman; Carl R. Adkins, Fayetteville; David F. Bell, Jr., Bluefield; John S. Cook, Welch; John M. Daniel, Beckley; Albert C. Esposito, Huntington; John P. Franz, Wheeling; C. A. Hoffman, Huntington; Muthusami Kuppusami, Welch; Jack Leckie, Huntington; Arthur E. Levy, Williamson; Thomas P. Long, Man; Houston B. Moore, Lewisburg; Joseph T. Skaggs, Charleston; Richard L. Slack, Point Pleasant; Charles E. Turner, Huntington; Robert Bruce Walker, Hamlin, and R. James Yates, Beckley.

**James E. Drake (left photo) Director of Congressional Relations, AMA Washington Office, speaks during the third general session of the State Medical Association's Annual Meeting in August. In the center photo, Dr. Robert D. Hess (right) of Clarksburg, then Chairman of the Association's Council, presents the Past President's Plaque to Dr. Stephen D. Ward of Wheeling, retiring Association President, during the final session of the Association's House of Delegates. On the right, also during the final House session, Doctor Ward administers the oath of office to Dr. L. Walter Fix of Martinsburg, the Association's new President.**

**Physician Services**

William N. Walker, Jr., Bridgeport, Chairman; Donald A. Blum, New Martinsville; Thomas A. Haymond, Masontown; Thomas S. Knapp, Charleston; Richard V. Lynch, Jr. Morgantown; Ralph S. Smith, Jr., Charleston; James M. Stevenson, Morgantown, and Patricia W. Williams, Morgantown.

**Long Range Planning**

Richard E. Flood, Weirton, Chairman: John B. Markey, Charleston: John A. Mathias, Buckhannon; Louis C. Palmer, Bridgeport, and Harry Shannon, Parkersburg.

## Mrs. Gary G. Gilbert Installed As Auxiliary President

Mrs. Gary G. Gilbert of Huntington assumed the Presidency of the Auxiliary to the West Virginia State Medical Association at the group's 56 Annual Meeting at the Greenbrier in White Sulphur Springs. August 20-23.

Mrs. Gilbert was installed by Mrs. John F. Vaughan of Vancouver, Washington, President of the Auxiliary to the American Medical Association, who was an honor guest.

Mrs. Gary G. Gilbert

Mrs. Gilbert's husband is an obstetrician-gynecologist.

The Auxiliary elected Mrs. Logan W. Hovis of Vienna as President Elect and the following additional officers:

Mrs. E. M. Spencer of Bluefield, Vice President; Mrs. Charles E. Turner, Huntington, Recording Secretary; Mrs. William M. Jennings III, Huntington, Corresponding Secretary; Mrs. T. Keith Edwards, Bluefield, Treasurer; Mrs. M. Bruce Martin, Huntington, Parliamentarian;

Mrs. Charles E. Haislip, Fairmont, Northern Regional Director; Mrs. Herbert E. Warden, Morgantown, Eastern Regional Director; Mrs. John J. Bryan, Bluefield, Southern Regional Director; Mrs. Winfield C. John, Huntington, Western Regional Director, and Mrs. Charles C. Weise, Charleston, Central Regional Director.

**Committee Appointments**

Mrs. Gilbert also announced these appointments of committee chairmen:

Mrs. Logan W. Hovis, Vienna, Membership; Mrs. E. M. Spencer, Bluefield, Members-at-Large; Mrs. Harvey D. Reisenweber and Mrs. L. Walter Fix, both of Martinsburg, and Mrs. George Naymick, Newell (Hancock County), Health Careers Loan Fund; Mrs. Mehmet V. Kalaycioglu, Shinnston, "Shape Up for Life" AMAA Theme; Mrs. Robert S. Robbins and Mrs. John W. Kennard, both of Wheeling, AMA-ERF; Mrs. J. L. Mangus, Charleston, and Mrs. D. Sheffer Clark, Huntington, Long Range Planning; Mrs. W. Gene Klingberg, Morgantown, Press and Publicity;

Mrs. Richard S. Kerr, Morgantown, News Bulletin Editor; Mrs. Charles E. Andrews, Morgantown, News Bulletin Circulation; Mrs. Larry C. Smith, Huntington, Archives and Historian; Mrs. Robert W. Lowe, Huntington, Necrology; Mrs. J. Dennis Kugel, Charleston, Finance;

Mrs. Herman Fischer, Bridgeport, By-Laws and Handbook; Mrs. Harry Shannon, Parkersburg, Legislation; Mrs. Anthony G. DiBartolomeo, Morgantown, Caducean's Liaison, WVU; Mrs. Robert W. Coon, Huntington, Caducean's Liaison, Marshall;

**Shown above are some of the new officers of the Auxiliary to the State Medical Association who were elected during the Auxiliary's 56th Annual Meeting August 20-23 at the Greenbrier in White Sulphur Springs. In the front row, from left, are Mrs. E. M. Spencer, Bluefield, Vice President; Mrs. Gary G. Gilbert, Huntington, President; Mrs. Logan W. Hovis, Vienna, President Elect, and Mrs. Charles E. Turner, Huntington, Recording Secretary; second row, from left, Mrs. Herbert E. Warden, Morgantown, Eastern Regional Director; Mrs. Winfield C. John, Huntington, Western Regional Director; Mrs. Charles C. Weise, Charleston, Central Regional Director, and Mrs. T. Keith Edwards, Bluefield, Treasurer.**

Mrs. M. Bruce Martin, Huntington, Convention; Mrs. George A. Curry, Morgantown, Southern Medical Councilor; Mrs. Winfield C. John, Huntington, Southern Medical Vice Councilor; Mrs. D. Sheffer Clark, Huntington, Youth and Children, and Mrs. Harry S. Weeks, Jr., Wheeling, WESPAC.

**Active Since 1968**

Mrs. Gilbert (Ruth) has been an active auxilian since 1968. She has been on the Board of the Cabell County Auxiliary since 1968, serving as President in 1973-74.

She has been on the State Auxiliary Board for seven years, holding the offices of Corresponding Secretary, Regional Director and Recording Secretary before becoming President Elect.

Born in Tennessee, Mrs. Gilbert has lived in Huntington since she was three years old. She attended the University of Tennessee in Memphis. Her parents are Mr. and Mrs. William I. Carroll, who recently retired to their farm in Tennessee.

Doctor Gilbert, a native of Huntington, received his M. D. degree from West Virginia University School of Medicine. He and Mrs. Gilbert were married in 1955. They are the parents of four children: Gary Gene Gilbert, Jr., and Michael Scott Gilbert, both students at Marshall University; Laura Elizabeth Gilbert, studying at Randolph-Macon Womans College in Lynchburg, Virginia, and Christopher Todd Gilbert, a senior at Virginia Episcopal Preparatory School, also in Lynchburg.

Mrs. Gilbert is active in her church, and serves on the Board of the Huntington Womans Club.

## AMA House Action Covers Wide Range of Topics

*(Editor's Note: The following material, offering a summary of major actions by the American Medical Association House of Delegates at its annual meeting in Chicago in late July, is provided by West Virginia's AMA delegation—Drs. Frank J. Holroyd of Princeton and Richard E. Flood, Weirton, Delegates; and Jack Leckie of Huntington and Harry S. Weeks, Jr., Wheeling, Alternate Delegates.)*

With 279 delegates this was the largest House in the history of the Association. Although the American College of Surgeons had withdrawn its representation, the House voted to keep the seat open in the hopes that ACS would reconsider. In another action, the House voted to terminate representation from the Canal Zone since it no longer meets the criteria for a constituent society.

It was a busy meeting, with the House acting on 249 resolutions and reports pertaining to

**On the left, Dr. L. Walter Fix of Martinsburg and family pose for an informal photo following the installation of Doctor Fix as President of the State Medical Association during the Association's Annual Meeting in August. From left, front row, are grandchildren Matthew Irving, Christopher Nelson, Rachel Sites, Carleen Irving and Rebecca Sites; second row, from left, daughters Linda Irving and Marilyn Nelson; Doctor Fix; wife, Catherine C. Fix, and daughter, Anne Fix; third row, from left, daughter, Elaine Merceruio and husband, David; son-in-law, Dale Sites, and daughter, Pamela Sites. In the right photo, during the Association's first House session, Dr. Donald C. Carter (right) of Morgantown presents a silver tray as a Distinguished Service Award of the West Virginia District Branch, American Psychiatric Association, to Dr. Stephen D. Ward of Wheeling, a psychiatrist and then Association President. The award was presented for meritorious service to the District Branch and to the psychiatric profession in general. Doctor Carter, a psychiatrist, is representative of the District Branch to the APA Assembly.**

virtually every interest and concern of the practicing physician.

The best news was an item omitted from the agenda at this meeting — a dues increase. We had thought that we would be considering a dues increase, but the financial strength of the AMA is such that action on a dues increase was postponed. There are economic indications that there will be action on a dues increase at the 1981 annual meeting for implementation in 1982.

Major issues before the House included a revision of the principles of medical ethics; JCAH standards for hospital accreditation; medical education accreditation; an important study of health maintenance organizations; national health insurance; a question of the proper role of the physician in executions; and membership.

#### Principles Of Medical Ethics

By more than a two-thirds vote, we adopted a revised version of the principles of medical ethics proposed by an ad hoc committee of the House. After two years of study and consultation with medical societies and individuals, the committee submitted a revision consisting of a preamble and seven sections. The principles were last revised in 1957.

#### Joint Commission On Accreditation Of Hospitals

The House directed some severe criticism at the JCAH and its survey procedures. Several resolutions expressed deep dissatisfaction with JCAH requirements and the conduct of surveys. A Board of Trustees report said that the JCAH accreditation manual for hospitals tends to prescribe methods of organizing the hospital and the medical staff rather than concentrating on the quality and excellence of patient care.

The House directed the Board to invite a series of changes for improving the hospital accreditation process.

#### Medical Education Accreditation

In a mood of conciliation and cooperation, the House authorized the Board of Trustees to eliminate dual accreditation by the LCCME and the AMA. You will recall that one year ago we voted to withdraw from the LCCME (Liaison Committee on Continuing Medical Education).

The House adopted a report outlining proposed changes in accrediting medical education at all levels through ongoing discussions with the parent organizations of the Coordinating Council on Medical Education and the liaison committees.

The Board's report said that accreditation of graduate medical education should be modified

## Association's 1981 Meeting To Be One Day Shorter

By House of Delegates action this year, the 114th Annual Meeting of the State Medical Association again set for the Greenbrier in White Sulphur Springs will be shortened a day. It will be held on Thursday, Friday and Saturday, August 20-22, 1981.

The pre-convention meeting of the Council and the first session of the House of Delegates will be held on Thursday, instead of on Wednesday as has been the case in past years.

The number of general scientific sessions will be reduced from three to two, and will be held on Friday and Saturday mornings. Opening convention exercises will precede the Friday morning scientific program.

Preliminary plans call for no other basic changes in the Friday and Saturday format, which again will find various scientific sections and societies holding breakfast and other scientific and business meetings on Friday and Saturday; and the House meeting for the second and final time on Saturday afternoon.

A resolution adopted by the House in 1979 directed that a study be made of possible changes in the meeting structure, for expressed purposes hopefully of reducing time physicians would need to be away from their offices; and of making it more economically attractive to the Association's younger physician members.

A committee headed by Dr. Robert D. Hess of Clarksburg, Chairman of the Council in 1979-80, recommended to the House that the Association continue to meet at the Greenbrier, in conjunction with the Auxiliary, but that the meeting be shortened one day.

Meanwhile, while further logistic and other arrangements are launched for 1981, the convention's Program Committee, headed by Dr. T. Keith Edwards of Bluefield, already has held its initial meeting and begun work on the scientific offerings.

Other Committee members who held their first meeting at the Greenbrier on Friday, August 22, are Drs. John B. Markey of Charleston, Stanley J. Kandzari of Morgantown, Ruth C. Harris of Huntington, Jerome C. Arnett, Jr., of Elkins and Harvey D. Reisenweber, Martinsburg.

to make residency review committees responsible for actual accrediting decisions. The Liaison Committee on Graduate Medical Education functions would then change to policy development and appeals.

The Board said no changes would be needed in the accreditation of undergraduate education.

The House also called for continued support of voluntary continuing medical education and asked state associations and specialty societies to support a moratorium on additional mandatory CME and mandatory recertification programs.

#### Health Maintenance Organizations

In adopting a report on health maintenance organizations, the House acted to continue its policy of neutrality and fair market competition among all systems of health care delivery.

We also reaffirmed a policy against preferential subsidies to any one form of health care delivery and protested the use of federal tax money for advertising to promote HMOs.

#### National Health Insurance

The AMA policy pertaining to national health insurance was reaffirmed by the House.

The Board of Trustees was granted a degree of flexibility in dealing with Congress on this issue within the parameters of established policy. The AMA will continue to advocate in a positive manner the superiority of a voluntary, free-choice method of medical health care delivery compared to a system dominated and controlled by the federal government.

The AMA advocates the maintenance of high-quality medical care within the framework of private insurance.

#### Physician's Role In Executions

Considerable media attention was devoted to a Judicial Council report regarding physician participation in executions. This was a timely report since four states have laws providing executions by lethal injection of a pharmological substance.

The House adopted the report prohibiting a physician's participation in an execution. However, a physician may continue to make a determination or certification of death as currently provided by law in any situation.

The report also states that an individual's opinion on capital punishment is the personal, moral decision of the individual.

#### Membership

Earlier in this report, we mentioned the likelihood of a dues increase proposal coming up at the 1981 annual meeting next June. The unprecedented rate of inflation is having a damaging effect on the Association.

Dr. James Sammons, AMA's Executive Vice President, reported that next year inflation is going to cost the AMA $6.5 million, and the last few years alone inflation has cost the AMA at least $12 million.

Doctor Sammons also reported that we cannot realistically anticipate any dramatically large, new sources of revenue, and that membership dues will continue to be the basic source of revenue for the Association.

Now, you and I can't do much about inflation. But we can do something about bringing in new members and keeping the members we have. The House of Delegates adopted a report encouraging state and county societies to set AMA membership goals for the coming year.

#### Other Business Items

Obviously, with so many items of business, we can only touch briefly on a few of major interest.

AMA House meetings provide a unique educational opportunity and we would encourage you to attend and participate. Any member of the Association may present testimony at reference committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

If you can't come to the meeting, you can still be represented through your delegate. Let your delegation know your opinions. You can also prepare a resolution and request that it be submitted to the House.

Many, many AMA policies began with an individual physician who had a good idea and coaxed it through the democratic process.

## The Virginias Neurosurgical Society Schedules Meet

The Neurosurgical Society of the Virginias will meet January 22-24, 1981, at the Homestead, Hot Springs, Virginia. Further information may be obtained from Albert G. Loew, Jr., M. D., Program Chairman, at 3500 Queen Street, Portsmouth, Virginia 23707.

## Membership For Osteopaths Proposed By Amendments

Proposed amendments to the Medical Association's Constitution and By-Laws to open membership to doctors of osteopathic medicine, and to students enrolled in accredited schools of osteopathic medicine in West Virginia, were introduced into the House of Delegates during the Association's Annual Meeting in August.

Because a constitutional amendment must lie over for a year and be made known to the Association membership by publication or other methods, action on the matter will be an order of business at the first House of Delegates session in August, 1981.

Here are the proposed amendments, with language changes which would result in the existing Constitution and By-Laws set out in italics:

### PROPOSED AMENDMENTS TO THE CONSTITUTION

(Originated by the Executive Committee and Council, April 13, 1980; To Be Acted Upon Finally at the First Session of the House of Delegates in 1981)

Amend Article IV, Sections 2 and 5, to read as follows:

Section 2. Members: Membership in this Association shall be limited to doctors of medicine *and osteopathy* licensed to practice in West Virginia who are members of a component medical society of the West Virginia State Medical Association; and student enrolled in accredited schools of medicine *or osteopathic medicine* in West Virginia granting Doctor of Medicine or *Doctor of Osteopathy* degrees.

(Note: The purpose of this amendment is to permit doctors and students of osteopathic medicine to become members of the West Virginia State Medical Association.)

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Section 5. Student members shall be those persons enrolled in accredited schools of medicine *or osteopathic medicine* in West Virginia granting Doctor of Medicine *or Doctor of Osteopathy* degrees who are qualified for membership under the By-Laws of this Association.

(Note: The purpose of this amendment is to permit students of osteopathic medicine to become members of the Student Section of this Association.)

### PROPOSED AMENDMENTS TO THE BY-LAWS

(Originated by the Executive Committee and Council, April 13, 1980)

Amend Chapter I, Section 1, to read as follows:

Sec. 1. The name of a physician on the properly certified roster of members of a component society shall be prima facie evidence of membership in this Association, provided he has paid local and state dues and any current assessment, and provided further that he is licensed to practice medicine in West Virginia.

The membership shall also include, upon payment of state dues and any current assessment, a student enrolled and working toward a Doctor of Medicine *or Doctor of Osteopathy* degree, in any accredited school of medicine *or osteopathic* medicine in West Virginia; provided, further, that the academic status of each medical *or osteopathic* student applicant for membership shall be certified by the dean of his medical *or osteopathic* school.

(Note: The purpose of this amendment is to permit students of osteopathic medicine to become members of the Student Section of this Association.)

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Amend Chapter I, Section 6, to read as follows:

Sec. 6. The active membership of this Association shall consist of those physicians or doctors of medicine *and doctors of osteopathy* who are actively engaged in the practice of medicine *or osteopathy*, who hold a degree of Doctor of Medicine, or Bachelor of Medicine, *or Doctor of Osteopathy*, who are licensed to practice medicine in the State of West Virginia, and who are members of one of the component societies in this Association.

The grant of a temporary permit to practice medicine by the *West Virginia Board of Medicine* or the *West Virginia Board of Osteopathy* shall entitle the holder of such temporary permit to full privileges of active membership in the State Medical Association during the period covering such temporary permit, provided such permit holder has satisfied the requirements for membership in his component society. There shall be no remission of dues or assessments for any portion of any fiscal year not covered by the terms of a temporary permit to practice medicine in this State, or when said temporary permit has been revoked by competent authority during said fiscal year. The fiscal year shall begin on January 1 and end on December 31 each year.

The honorary membership of this Association shall consist of those physicians who have attained outstanding eminence in the medical profession; have been nominated for honorary membership by their component societies; and have been elected to such membership by a majority vote of the Council and the House of Delegates of the Association.

The retired membership of this Association shall consist of those physicians who have been active members, but have retired from professional activity. Nominations for this category shall be forwarded by the appropriate component societies to the executive secretary for submission to Council for election.

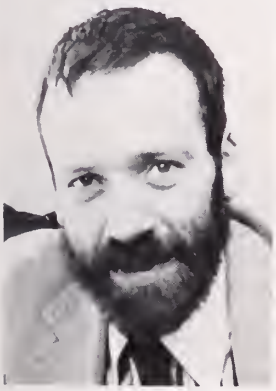
Honorary and retired members shall be exempt from the payment of dues or assessments. They shall have the privilege of the floor in any open session of the Association, but shall not have the right to make or second motions, to vote, or to hold any elective office in this Association, except that they may hold elective or appointive committee membership.

(The effect of this amendment is to broaden the active membership category to include doctors of osteopathy.)

## October 9 Registration Deadline For Geriatric Conference

A registration deadline of October 9 has been set for Marshall University School of Medicine's continuing education conference on geriatric medicine scheduled October 16-17.

Colin Currie, Member of the Royal College of Physicians, will open the conference with a discussion of "What's Different About the Elderly Patient?"


Colin Currie, MRCP

To be held at Marshall Memorial Student Center, the conference offers 12 hours of Category 1 continuing medical education credit for the Physician's Recognition Award of the American Medical Association and 12 and one-third hours of Prescribed credit by the American Academy of Family Physicians.

Doctor Currie, one of several nationally-known leaders in geriatric medicine on the conference faculty, is a senior lecturer for the University Department of Geriatric Medicine at City Hospital, Edinburgh, Scotland. Currently, he is the Visiting Professor in the Duke Watts Family Practice Program at Duke University Medical Center.

Other guest faculty members include: Morton D. Bogdonoff, M. D., Cornell University; Richard Bozian, M. D., University of Cincinnati; Thomas G. Skillman, M. D., Ohio State University; Joseph E. Johnson II, M. D., Wake Forest University; Donald Vidt, M. D., Cleveland Clinic Foundation; Joseph R. Bianchine, M. D., Ph. D., Ohio State University; Robert P. Granacher, M. D., University of Kentucky, and Theodore M. Cole, M. D., University of Michigan.

Members of the Marshall Medical School serving as faculty include: Bruce S. Chertow, M. D.; John C. Huntwork, M. D.; Maurice A. Mufson, M. D.; Charles Yarbrough, M. D.; William C. Graham III, M. D.; Donald E. Melnick, M. D., and Donald S. Robinson, M. D.

The physician registration fee, which includes lunch both days, will be $60. The fee for other health care professionals will be $40.

Additional information on the conference or registration materials may be obtained by calling Charles W. Jones, Ph. D., Continuing Medical Education director, MU School of Medicine, at (304) 696-4822.

## AAP 50th Anniversary Meeting In Detroit In October

Adolescent health care, sudden infant death, sexual abuse, childhood cancer, sports medicine, and learning disorders will be among the topics discussed when the American Academy of Pediatrics holds its Golden Anniversary Annual Meeting, October 25-30, at Detroit Plaza Renaissance Center, Detroit, Michigan — founding city of the Academy.

The Academy's special anniversary program will open Saturday and Sunday with a series of seminars, concentrating on such subjects as pediatric psychiatry, newborn intensive care, allergy and immunology, pediatric cardiology, and infectious diseases.

Plenary sessions open to all meeting attendees are scheduled for Saturday night, Monday morning, all day Tuesday, and Wednesday and Thursday mornings. Saturday's session, "Saturday Night Live," will offer all registrants

a unique opportunity to pose questions to three of the leading pediatricians in the country in a no-holds-barred program.

The Monday morning session will feature keynote speaker David E. Rogers, M. D., President of the Robert Wood Johnson Foundation, Princeton, New Jersey, who will present "An Internist's view of Pediatrics: Past, Present and Future." Other topics of interest on the Monday program will include child passenger safety, a history of immunology, new concepts in the diagnosis of immunodeficiency disease, collagen disease, and recurrent infections.

Tuesday and Wednesday plenary sessions will cover a variety of subjects such as newer antibiotics, abnormalities in metabolism, pediatric surgery, childhood diabetes, and growth disorders. The Thursday session will consider such topics as neonatal seizures, adolescent depression, the use of ultrasound, and pediatric gynecology.

A series of 43 round table discussion groups are scheduled for Sunday through Thursday. Sessions will be devoted to such topics as sexual abuse, failure to thrive, nuclear medicine, Sudden Infant Death Syndrome and Near Miss, teaching parenting, management of psychological problems, and care of the chronically ill child. The various Committees of the AAP Council on Pediatric Practice will offer round tables on a variety of pediatric practice issues including Medicaid reform, health resources for rural children, emergency care, innovative practice management ideas, and a special presentation by the federal Select Panel on the Promotion of Child Health.

Informal breakfast and luncheon discussion groups covering a variety of topics will be held throughout the week. Registration for these sessions will be on site at the meeting.

## Association Urges Members To Vote November 4

The West Virginia State Medical Association's leadership has reminded members that the November 4 general election shapes up as a critical one for Medicine and those it serves.

"Medicine has a major stake in races at every level," the Association noted. It urged physicians to "know your candidates and things for which they stand—and above all else, vote on November 4."

# *Medical Meetings*

Oct. 4-9—AAFP—Ninth World Conference on Family Med. of WONCA, New Orleans.

Oct. 9-11—Am. Cancer Society, Los Angeles.

Oct. 10-12—Pediatric Approach to Common Neurological Problems (Johns Hopkins), Ocean City, Md.

Oct. 16-17—Geriatric Conference (MU School of Med.), Huntington.

Oct. 17-19—AMA Regional Meeting, Huron, Ohio.

Oct. 18-21—International Food Allergy Symposium III, Boston.

Oct. 19-23—Am. Public Health Assn., Detroit.

Oct. 19-24—ACS Clinical Congress, Atlanta.

Oct. 24-26—AMA Regional Meeting, Philadelphia.

Oct. 26-30—Am. College of Chest Physicians, Boston.

Oct. 29-Nov. 1—Fourth National Conference on the Impaired Physician (AMA, Med. & Chirurgical Faculty of Md.), Baltimore.

Nov. 2-7—Am. Academy of Ophthalmol., Chicago.

Nov. 8—Rowland H. Burns, M. D., Memorial Critical Care Conference (MU School of Med.), Huntington.

Nov. 9-13—International Congress for Interferon Research, Washington, D. C.

Nov. 10-11—Reconstructive Surgery of the Hip (Johns Hopkins), Baltimore.

Nov. 12-15—Am. Heart Assn., Miami.

Nov. 13-15—Southern Thoracic Surgical Assn., White Sulphur Springs.

Nov. 13-15—A National Forum on Comprehensive Cancer Rehabilitation and its Vocational Implications (Va. Dept. of Rehabilitative Services, MCV), Williamsburg, Va.

Nov. 14-16—AMA Regional Meeting, New York City.

Nov. 16-19—Southern Med. Assn., San Antonio, Texas.

**1981**

**Jan. 23-25—14th Mid-Winter Clinical Conference, Charleston.**

Feb. 22-25—Southeastern Surgical Congress, New Orleans.

March 8-12—Society of Head & Neck Surgeons; and Am. Society for Head & Neck Surgery, Phoenix, Ariz.

April 8-11—Tenn. Med Assn., Knoxville.

May 16-20—Ohio State Med. Assn., Cleveland.

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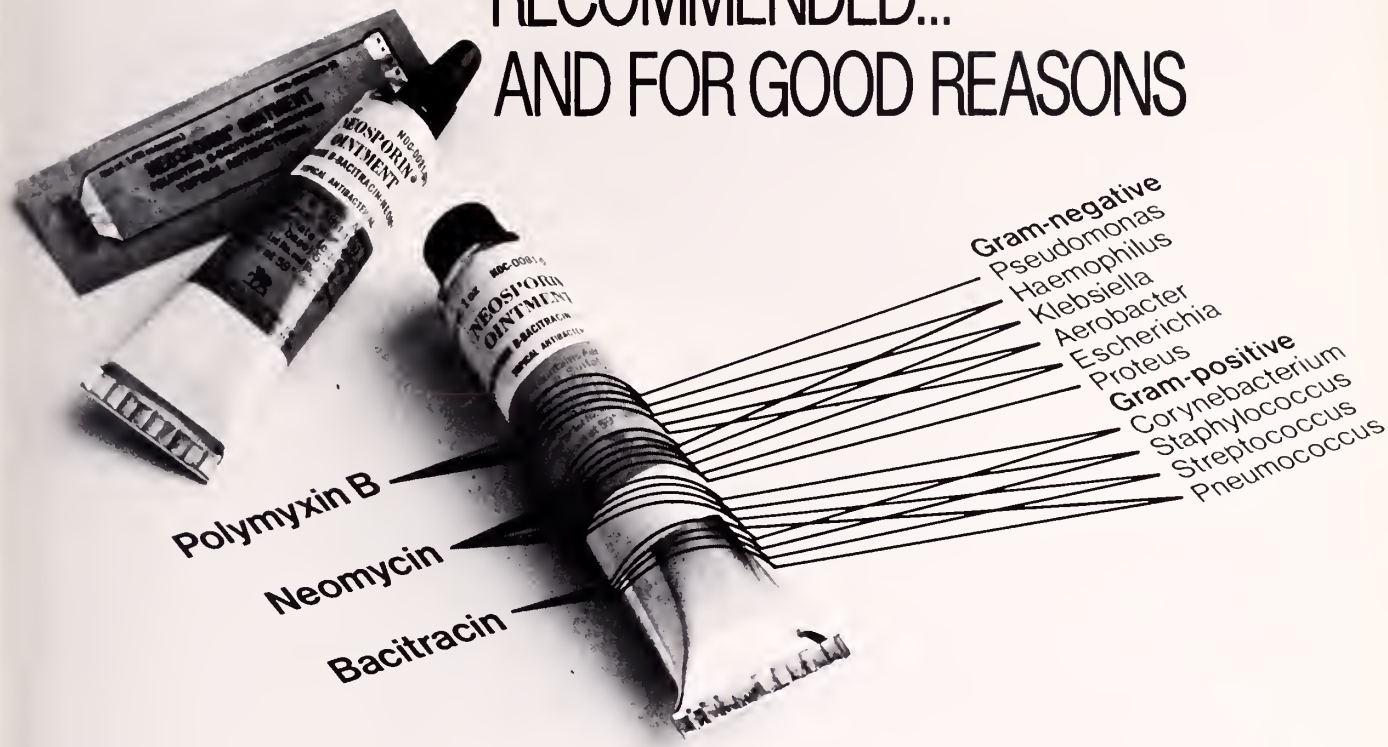


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**ARNING:** Because of the potential hazard of nephro- icity and ototoxicity due to neomycin, care should be ercised when using this product in treating extensive rns, trophic ulceration and other extensive conditions ere absorption of neomycin is possible. In burns where re than 20 percent of the body surface is affected, pecially if the patient has impaired renal function or is eiving other aminoglycoside antibiotics concurrently, t more than one application a day is recommended

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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# WVU Medical Center
# –News–

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## Weinstein Heads Department Of Ophthalmology

George W. Weinstein, M. D., a former faculty member at the University of Texas Medical School at San Antonio, has been named Professor and Chairman in the Department of Ophthalmology.

He succeeds Robert R. Trotter, M. D., who had served as Chairman of Ophthalmology since 1961. Doctor Trotter has retired from the faculty and will enter private practice.

George W. Weinstein, M. D.

"We are indeed fortunate that an ophthalmologist of Doctor Weinstein's stature has accepted the chairmanship of our department," Dean John E. Jones, M. D., of the School of Medicine said.

Doctor Weinstein, who had been a member of the University of Texas Medical School faculty since 1970, was Professor and Acting Chairman of the Department of Ophthalmology at the time of his departure. He formerly taught at Georgetown University and at Johns Hopkins University schools of medicine.

A graduate of the University of Pennsylvania, he received his medical degree from State University of New York's Downstate Medical Center in Brooklyn, where he also completed his residency training.

He currently is serving as an Associate Examiner of the American Board of Ophthalmology and as Associate Secretary of the American Academy of Ophthalmology. He has been Editor-In-Chief of the journal, Ophthalmic Surgery, since 1971.

Doctor Weinstein is the author or co-author of more than 40 journal publications detailing his research in such areas as retinal damage, glaucoma, conjunctival malignant melanoma, ophthalmic surgery and intraocular lenses.

## Tests Of Marijuana In Cancer Nausea Relief Begin

Clinical trials of Delta-9-tetrahydrocannabinol (THC), the active agent in marijuana, were getting under way last month.

In its first authorized medical use in West Virginia, THC will be tested for its effectiveness in preventing or relieving nausea and vomiting in cancer patients on chemotherapy.

Peter C. Raich, M. D., said planning had been completed, and selected patients were to begin receiving THC when approval was received from the U. S. Food and Drug Administration. Doctor Raich is Professor of Medicine and Section Chief of Hematology-Oncology.

Doctor Raich said 80 to 100 patients are expected to participate in the drug trials during a year's time. Enrollment is voluntary and will be limited to those patients for whom standard medication has not provided significant relief.

Patients will be screened carefully for physical or psychological problems which could be affected adversely by use of THC. They will be monitored closely for changes in mental processes, excessive drowsiness or other undesirable side effects.

All patients in the study will receive THC, Doctor Raich said. Basically, they will be divided into three groups — those who receive THC in a pill form, those who will take oral THC plus one of the standard medications to prevent nausea and vomiting, and those getting THC by inhalation or smoking marijuana cigarettes.

"Initially, we will start with a standard dose of THC and escalate it as deemed necessary or possible depending on its effectiveness and side effects," he said.

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# Third-Party News, Views and Program Concerns

## State Bureau Distributes Pelvic Infection Information

Information on the prevention and treatment of gonococcal pelvic inflamatory disease (PID) curently is being distributed to the West Virginia medical community by the Bureau of Venereal Disease Control, State Department of Health.

Ronald G. Bryant, Public Health Advisor for the Bureau, said this information was being distributed because "it is believed that much of the medical costs associated with this infection can be avoided by early diagnosis and proper treatment on an outpatient basis along with patient counseling to insure proper follow-up care, contact referral and use of preventive methods."

Gonococcal PID is the most frequently reported complication of gonorrhea, Bryant continued, and also reportedly is the most common cause of infertility among young women today in our country.

The Bureau suggests the following gonococcal PID care and prevention guidelines:

1. All females of child-bearing age seen by a clinician for complaints requiring a pelvic examination, particularly females with PID symptomatology, should receive a bimanual examination and a gonorrhea culture test.

2. All patients should be counseled to insure adherence to post-treatment testing schedules (cure test culture 7 to 14 days following completion of treatment; rescreening culture is strongly suggested 30 to 45 days following treatment).

3. PID patients should receive an appropriate early medical follow-up to determine their *clinical response* (3 to 5 days after initiation of treatment).

4. A contact interview is necessary to identify all infected sexual partners, most of whom will be asymptomatic carriers.

5. An expeditious referral of the sexual partners of gonococcal PID patients for diagnosis and appropriate treatment is vital to the prevention of repeat episodes of this complication of the disease and permanent damage to the reproduction organs.

To obtain additional consultation, including drug regimens of choice, physicians may call the State Department of Health. The toll-free number is 1-800-642-8244.

## Decision Against Removing Nitrite From Foods

The following statement recently was issued by Dr. Jere E. Goyan, Commissioner of the Food and Drug Administration, and Carol Tucker Foreman, Assistant Secretary for Food and Consumer Services of the U. S. Department of Agriculture:

"A group of independent pathologists has completed an extensive review of the study conducted at the Massachusetts Institute of Technology (MIT) that led us in 1978 to consider the need to phase out nitrite as a preservative in cured meats and poultry.

"The pathologists evaluated 50,000 tissue slides from the 2,000 rats in the study and found a 'much lower incidence of lymphoma' (cancers of the lymph system) than was originally reported.

"A committee of scientists from several government agencies has evaluated the pathologists' review and has concluded that insufficient evidence exists to support a conclusion that nitrite induced cancer in the rats, based on the MIT study.

"As a result of the review and evaluation, we have concluded there is no basis for FDA or USDA to initiate any action to remove nitrite from foods at this time.

"At the same time, we will continue to pursue our efforts to eliminate preformed nitrosamines from foods. Nitrosamines are chemicals formed when nitrite combines with naturally-occurring substances known as amines. Nitrosamines are known carcinogens. Efforts to eliminate or reduce nitrosamines from such disparate products as bacon and beer have been highly successful . . . "

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# Obituaries

### CHARLES H. GOODYKOONTZ, JR., M. D.

Dr. Charles H. Goodykoontz, Jr., retired general practitioner of Bluefield, Virginia, died on July 28 in a Bluefield, West Virginia, hospital. He was 70.

Doctor Goodykoontz practiced in Bluefield, West Virginia, for six years, and in Bishop, Virginia, for 37 years before retiring in 1979.

A native of Bluefield, West Virginia, he was graduated from Davidson College and received his M. D. degree in 1935 from the University of Pennsylvania. He interned at St. Luke's Hospital in Bethlehem, Pennsylvania.

Doctor Goodykoontz was a Retired Member of the McDowell County Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include the widow; two daughters, Mrs. Gordon Burnham of Long Island, New York, and Mrs. Charles Wilkens of Salem, Virginia; a son, Charles H. Goodykoontz III of Louisville, Kentucky, and a brother, William F. Goodykoontz of New York City.

* * *

### RALPH J. JONES, M. D.

Dr. Ralph J. Jones, Charleston cardiologist, died on August 21 in a hospital there. He was 70.

Doctor Jones was a member of the Kanawha Medical Society, the West Virginia State Medical Association, American Medical Association and American College of Physicians.

He was a native of Bridgeport and a veteran of World War II.

Doctor Jones was graduated from West Virginia University and received his M. D. degree in 1936 from Johns Hopkins University School of Medicine. He completed his internship, residency and postgraduate work at Baltimore City Hospitals and the University of Pittsburgh.

Survivors include the widow; a son, Richard H. Jones of Keswick, Virginia; a daughter, Mrs. Thomas N. Chewning of Seattle, Washington; a sister, Mrs. Pauline Coston of Bridgeport and three brothers, John H. Jones and Willis L. Jones, both of Bridgeport, and Samuel C. Jones of Brick Town, New Jersey.

# County Societies

### FAYETTE

The Fayette County Medical Society met on September 3 at Oak Hill Hospital.

Dr. Richard M. Thompson, Department of Radiology, Raleigh General Hospital, Beckley, was the guest speaker. His talk, "Diagnostic Nuclear Medicine," emphasized ventilation perfusion lung scans.—Daniel B. Doyle, M. D., Secretary.


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# Resolutions

Here are resolutions adopted by the House of Delegates of the State Medical Association at its final session on August 23 during the Association's Annual Meeting in White Sulphur Springs:

WHEREAS, The Joint Commission on Accreditation of Hospitals has performed admirably in the accreditation of hospitals; and

WHEREAS, However, The increasing Joint Commission on Accreditation of Hospitals requirements, some unreasonable, have become voluminous; and

WHEREAS, the requirements for documentation sometimes impede hospital functions and increase costs without assuring quality of care:

THEREFORE, BE IT RESOLVED, That the Joint Commission on Accreditation of Hospitals should be more selective in its inspection criteria that relate to quality of medical care, and the Joint Commission on Accreditation of Hospitals should be thus informed;

BE IT FURTHER RESOLVED, That the West Virginia State Medical Association's delegates to the American Medical Association propose to the AMA House of Delegates, at its interim meeting December 7-10, 1980, in San Francisco, adoption of this resolution.

---

WHEREAS, Kenneth G. MacDonald, Sr., a native of Chester, Pennsylvania, and a longtime resident of Charleston, West Virginia, has been a contributing force to his profession and to the community in which he resides; and

WHEREAS, Washington and Lee University conferred upon him the degree of Bachelor of Science; and

WHEREAS, Cornell University Medical College conferred upon him the degree of Doctor of Medicine; and

WHEREAS, Following an internship served at Lenox Hill Hospital in New York City, he entered into the service of his country being assigned to Gen. George S. Patton's 12th Evacuation Hospital as surgeon with the rank of Captain; and

WHEREAS, Upon returning to civilian life, he served a two-year residency in surgery at the Lenox Hill Hospital, and he did further postgraduate work in Surgical Pathology at New York University College of Medicine; and

WHEREAS, Following extensive training, he chose to establish practice in West Virginia, in the city of Charleston, where he was soon to gain a reputation for excellence of practice, as well as the admiration and confidence of his fellow physicians; and

WHEREAS, He was recognized for his leadership among his peers, being elected President of the West Virginia Chapter of the American College of Surgeons; President of the Kanawha Medical Society; Vice President and Secretary-Treasurer of the Society; Chairman of the Executive Council, and member of numerous state and local medical committees; and

WHEREAS, Doctor MacDonald's contribution to his community and to his fellow man include extensive service in the Boy Scouts of America, where he won the Silver Beaver Award, the highest award made to adult leaders; service to his church, the Baptist Temple of Charleston; Associate Member, United Church of Dorset and East Rupert, Vermont; member of the Dorset Library Association and Dorset Nursing Association; Past President of the American Business Club; long-time member, Charleston Rotary Club; Past Commander and Chief, Great Kanawha River Navy; member Executive Board, Charleston Boat Club; member Board of Governors, Southern West Virginia Automobile Association; member, U. S. Coast Guard Auxiliary; member, Robert E. Lee Associates of Washington and Lee University established to assure continued financial support for this great southern institution; and

WHEREAS, He was appointed Clinical Associate Professor of Surgery, CAMC, and serves on the staff of the WVU Medical School, Charleston Division; and

WHEREAS, He has been honored scholastically, having been awarded the Phi Beta Kappa Key; elected to Alpha Omega Alpha Medical Fraternity, and Phi Chi Medical Fraternity; and

WHEREAS, He holds the rank of Fellow, American College of Surgeons, and Diplomate, American Board of Surgery; and

WHEREAS, He was first elected Treasurer of the West Virginia State Medical Association in 1965, serving continuously by re-election until the present for a period of 15 uninterrupted years;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association commend Dr. Kenneth G. MacDonald, Sr., for his

lengthy tenure as Treasurer, as well as for his outstanding service to the medical profession; and

BE IT FURTHER RESOLVED, That the Secretary of the West Virginia State Medical Association spread upon the records of the Association this resolution in recognition of his services; and that a copy be presented Doctor MacDonald, as well as the President of the Kanawha Medical Society.

---

BE IT RESOLVED, That the Council of the West Virginia State Medical Association study trends in the cost and quality of medical education in West Virginia through appropriate Association committees during the upcoming year; and that a report on this matter be made to the House of Delegates at the next annual meeting in 1981.

---

## Necrology Report

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

**1979**

July 5—Donald M. Clark Petersborough, N.H.
July 31—Paul H. Nitschke Beckley
Aug. 28—Melvyn D. West Shepherdstown
Sept. 5—O. S. Campbell Grafton
Sept. 5—Edward J. Van Liere Morgantown
Sept. 14—George F. Grisinger, Jr. Fort Lauderdale, Fla.
Sept. 14—Thomas M. Klug Wheeling
Sept. 23—Virgil L. Curry Mableton, Ga.
Nov. 15—William E. McNamara, Jr. Wheeling
Nov. 26—Angelo S. Daniel Wheeling
Nov. 28—J. Foster Carr Huntington
Dec. 12—William C. Kappes Huntington
Dec. 15—O. M. Harper Clendenin

**1980**

Jan. 20—Edwin A. Trinkle Weston
Jan. 23—Stephen Mamick White Sulphur Springs
Feb. 8—William D. McClung Lewisburg
Feb. 23—Cornell L. Panoviciu Wheeling
Mar. 7—Earl S. Phillips Wheeling
Mar. 19—W. Beckett Martin Huntington
Mar. 24—Sherl J. Winter Beckley
Mar. 30—Ivan H. Bush Oak Hill
Apr. 3—Edward Shupala Parkersburg
Apr. 8—John S. Blagg South Charleston
Apr. 23—Richard E. Lewis St. Clairsville, Ohio
Apr. 30—Edward S. Phillips Wheeling
May 4—Charles I. Rogers Charleston
May 22—Arthur E. McClue Dunbar
June 2—Reverdy H. Jones Fairmont
July 22—Richard D. Kitching Charleston
July 28—Charles H. Goodykoontz Bishop, Va.
July 31—Mary Virginia Gallagher Charleston
Aug. 3—Carl B. Jarrell Charleston
Feb. 10, 1978—Eugene C. Hartman Parkersburg

(Whose death in 1978 was not reported to this office until after the 1979 Annual Meeting).

Respectfully submitted,

CHARLES R. LEWIS,
*Executive Secretary*

August 20, 1980.


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A. Kyle Bush, M. D.
J. W. Woodford, M. D.

**Gynecology and Obstetrics:**
Raymond W. Cronlund, M. D.

**Internal Medicine:**
E. G. Guy, M. D.
Karl J. Myers, Jr., M. D.
Wm. A. SanPablo, M. D.
C. S. Kadakia, M. D.

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Contact: E. G. Kreider, M. D.
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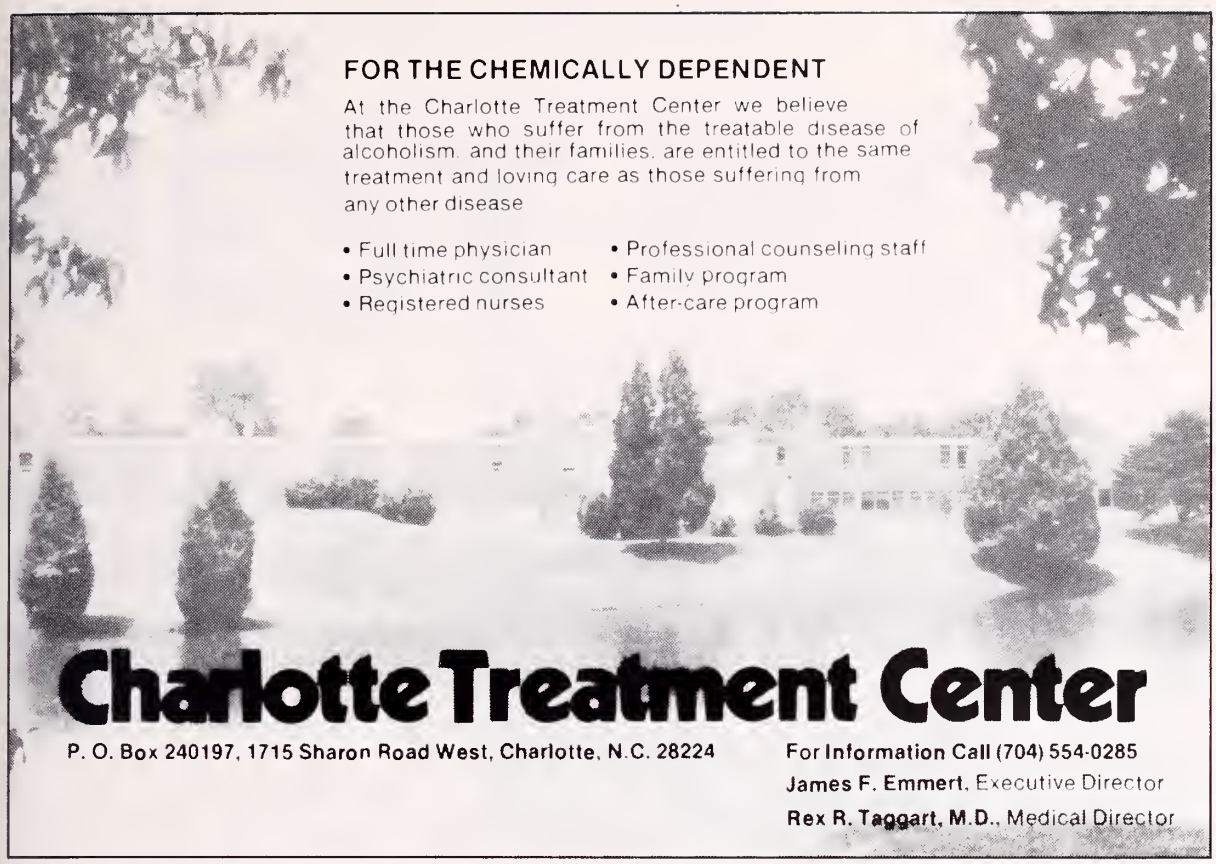


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M. C. Rosenberg, D. O. (Helvetia Clinic)
L. E. Soriano, M. D. (Marlinton Clinic)

**EMERGENCY MEDICINE:**
R. H. Plummer, D. O.
A. M. Fuller, M. D.
F. A. Khan, M. D.

**FAMILY PRACTICE:**
L. H. Valliant, M. D.
H. E. W. Gregor, M. D.

**INTERNAL MEDICINE:**
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# CONTENTS

**Scientific Articles**

Inverted Papilloma of Bladder—Tara C. Sharma, M. D.; Harold N. Kagan, M. D.; John P. Sheils, M. D.; and Charles A. Hoffman, M. D. 285

Ectopic Pregnancy: Its Occurrence in Two Community Hospitals Using Medical Audit Techniques For Review—John W. Durkin, Jr., M. D.; and John B. Bennett, M.B.B.CH. 287

Causes of Perinatal Mortality in a Community Hospital: Report of a Prospective Study, 1975 to 1978—Narinder N. Sehgal, M. D. 291

**Scientific Department**

Medical Grand Rounds From the West Virginia University Medical Center (Diagnosis and Treatment of Symptomatic Gastroesophageal Reflux) —Edited by Irma H. Ullrich, M. D. 295

**The President's Page**

Cost Containment—L. Walter Fix, M. D., President, W. Va. State Medical Association 300

**Editorials**

Risk Management and the Doctor 301
The Physician and the Public 301
Overall Impact? 302

**General News**

14th Mid-Winter Clinical Conference 303
AMA Delegates to Meet in San Francisco 304
Uniform Health Care Claim Form Approved 305
Planning Committee Offers Initial Goals 306
Diabetes, Aging Conference in Charleston 309
Cardiovascular Symposium January 28-31 309

**Special Departments**

WVU Medical Center News x
Third-Party News, Views, Program Concerns xii
Obituaries xiv
County Societies xvi
Book Review xvii
Classified Section xxii
Index To Advertisers xxiv

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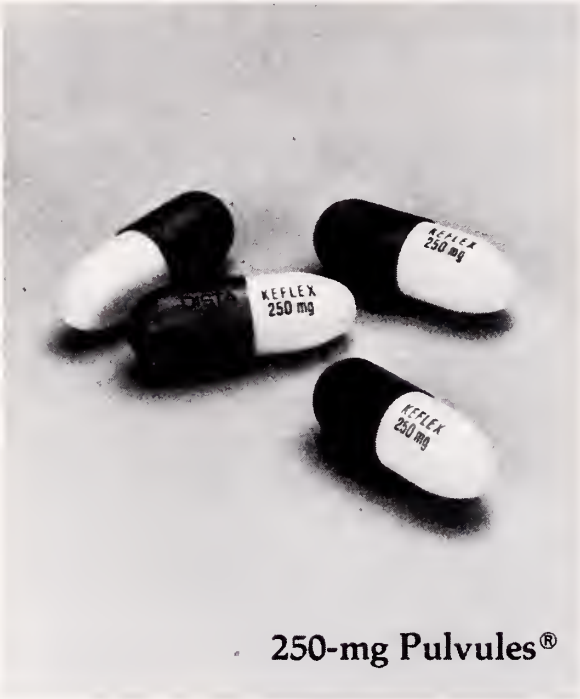


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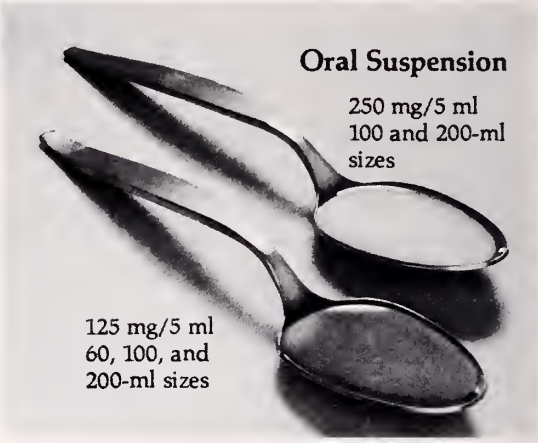

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A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

# EQUAGESIC® ©IV

## (meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS**: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

**CONTRAINDICATIONS**: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

**WARNINGS**: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

**USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.**

**Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.**

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

**PRECAUTIONS**: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

**ADVERSE REACTIONS**: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

**OVERDOSE**: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

**DESCRIPTION**: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication

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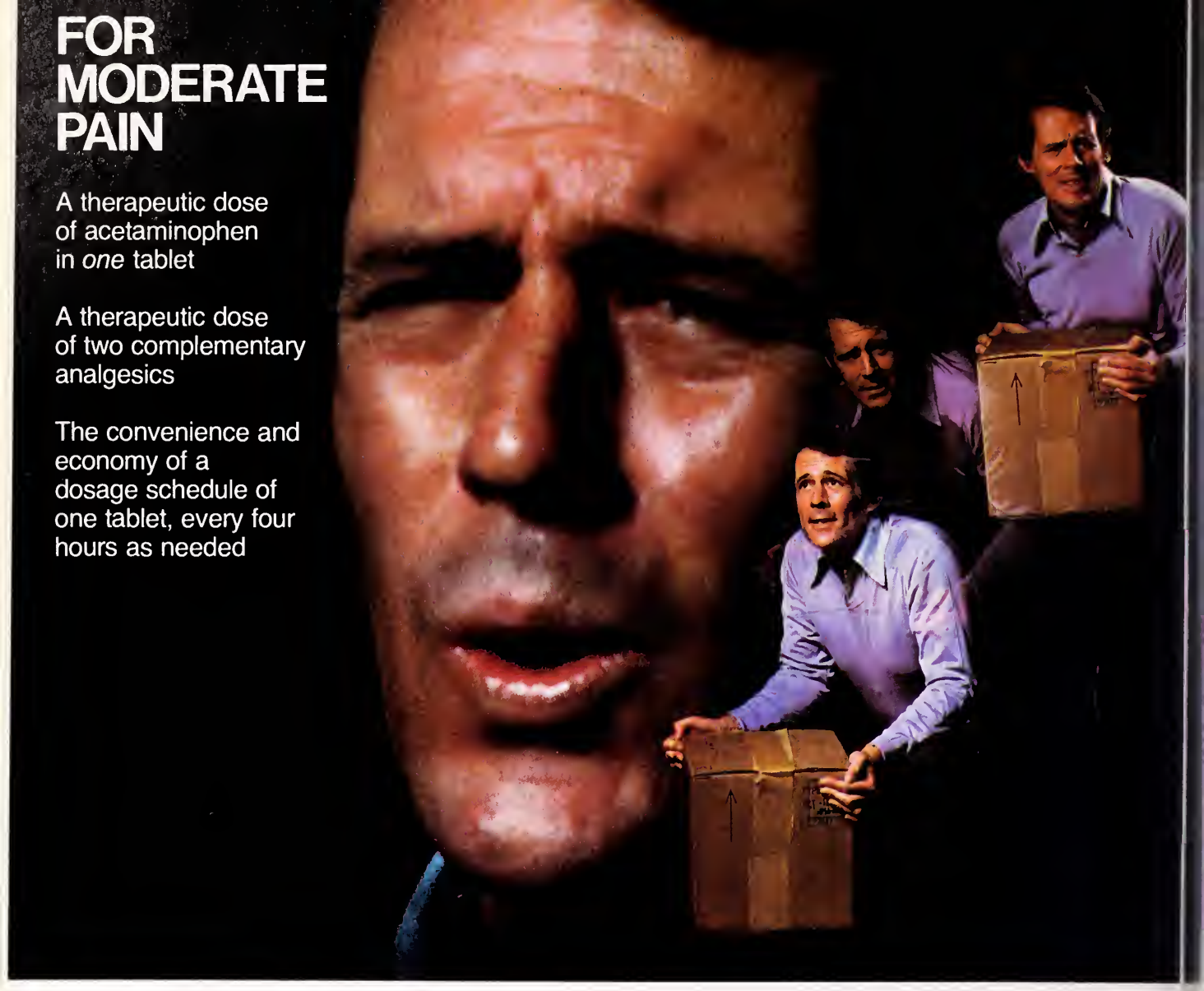


# WHY NOT WYGESIC® C IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

**WYGESIC—Abbreviated Summary**
**INDICATION**: For the relief of mild-to-moderate pain
**CONTRAINDICATION:** Hypersensitivity to propoxyphene or to acetaminophen.
**WARNINGS:** CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
**DRUG DEPENDENCE:** Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
**USAGE IN AMBULATORY PATIENTS:** Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery Patients should be cautioned accordingly
**USAGE IN PREGNANCY:** Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
**USAGE IN CHILDREN:** Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group
**PRECAUTIONS:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
**ADVERSE REACTIONS:** The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported
**DRUG INTERACTIONS:** Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.
**MANAGEMENT OF OVERDOSAGE:** SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects Overdoses of propoxyphene can cause delay of cardiac conduction as well as local or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours However, early recognition may be difficult since early symptoms may be mild and nonspecific Evidence of liver damage is usually delayed After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal
**TREATMENT:** Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated Gastric lavage may be helpful Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity Serial hepatic enzyme determinations are also recommended

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# Inverted Papilloma Of Bladder

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*Bladder tumors usually grow into the bladder cavity, making the cystoscopic diagnosis rather easy. On occasions they may grow down into the supporting tissue. They then are referred to as inverted papilloma of the bladder. Several cases have been reported in the literature.*[1-6] *We are reporting two cases of inverted papilloma of the bladder in patients who have had bladder tumors. The report stresses a vigilant search for granular or velvety-looking abnormal mucosal lesions that ordinarily may be regarded as chronic inflammatory changes in patients with bladder tumors.*

Case Report No. 1 (H. H. 361578-2) involves a 67-year-old white male who underwent suprapubic prostatectomy and excision of a superficial transitional cell carcinoma of the bladder in 1972. Subsequently, this patient was followed closely every three months cystoscopically. During this time span, he had three tumor recurrences that were electrocoagulated.

In the past 18 months, no recurrence was noted until April, 1977, when a yellowish, granular-looking lesion was noted over the trigone. The lesion was biopsied transurethrally. There was no evidence of gross bladder tumor recurrence. The tissue excised was interpreted as an inverted papilloma of the bladder (Figure 1). The patient was followed subsequently, but died a year later due to cardio-respiratory problems.

**Case No. 2 (K-C 356057-0)**

A 23-year-old single, Caucasian female was admitted with a typical history of right ureteral colic. Urinalysis showed microscopic hematuria. Intravenous pyelogram was normal. In view of the presence of microscopic hematuria, a cystoscopic examination was performed. At the time of cystoscopy, a papillary lesion was noted about 0.5 cm. lateral to the right ureteral orifice. There was considerable velvety, granular reaction over the trigone. The papillary lesion was resected and the area over the trigone was biopsied. The surrounding mucosa was electrocoagulated. The lesions were interpreted as transitional cell carcinoma of the bladder, Stage A, and inverted bladder papilloma (Figures 2 and 3).

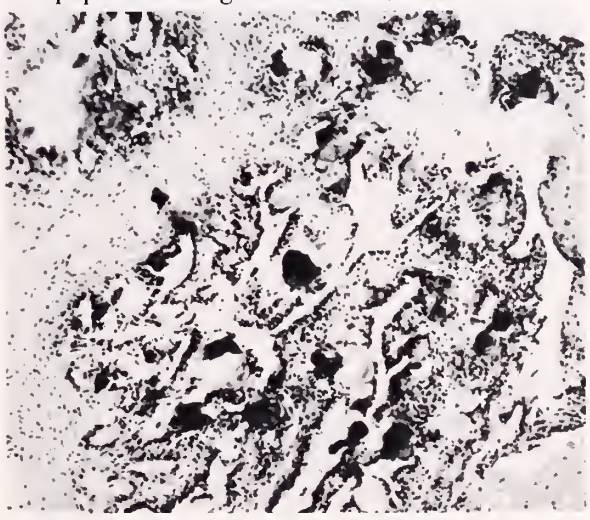

**Figure 1. Papillary inversion of transitional epithelium into underlying stroma. Psammoma bodies present within crypts. (H + E x 100)**

She was cystoscoped six months later, and a similar granular-looking lesion was biopsied which was interpreted as transitional papillary tumor of urinary bladder mucosa. To date, no recurrences have been noted, either in a papillary or granular form.

### Discussion

Urothelial tumors have a multicentric and multifocal potential. The epithelium at risk will form tumors. Gross tumors growing into the bladder cavity can be detected easily and treated endoscopically. The cases reported in this paper and in the literature[5,6] point towards a different growth pattern of the bladder tumors. This pattern may represent the beginning of the invasive or sessile-looking tumors. One may be misled by diagnosing and treating the projecting papillary lesion while overlooking the granular areas that may represent the inverted papilloma or carcinoma *in situ*. From such a lesion, it is conceivable that a deeply invasive or sessile lesion may evolve that will need more radical treatment.

**Figure 2. Papillary downward proliferation of surface epithelium and telangiectatic vessels present in the supporting tissue. (H + E x 40)**

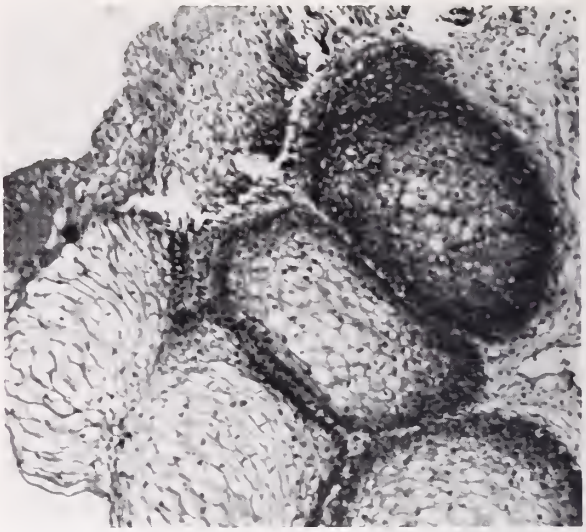

**Figure 3. Inverted nodular and papillary proliferation of squamous-type epithelium into supporting stroma. (H + E x 100)**

It is suggested that patients with recurrent bladder tumors, especially those who smoke heavily, should have a thorough search and appropriate biopsies from the suspicious-looking areas so that the lesion may be extirpated before it is beyond cure.

### References


1. Potts IF, Hirst E: Inverted papilloma of the bladder. *J Urol* 90:175, 1963.

2. Trites AEW: Inverted urothelial papillomas: Report of two cases. *J Urol* 101:216, 1969.

3. Assor D, Taylor JN: Inverted papilloma of the bladder. *J Urol* 104:715, 1970.

4. Pienkos EJ, Iglesias F, Jablokow VR: Inverted papilloma of bladder. *Urol* 2:178, 1973.

5. Tannenbaum M: Inverted papilloma: Urothelial tumor of benign biological potential. *Urol* VII:76, 1976.

6. Cameron KM, Lupton CH: Inverted papilloma of the lower urinary tract. *Brit J Urol* 48:567, 1976.

# Ectopic Pregnancy: Its Occurrence In Two Community Hospitals Using Medical Audit Techniques For Review*

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*Eccyesis, better known as ectopic pregnancy, is defined as the implantation of a fertilized ovum in a site other than the endometrial cavity. In a previous publication Malt described the use of medical audit techniques to retrieve information for medical care review and possible publication.*[1] *This report is based on a study using the medical audit system for the retrieval of information.*

To satisfy the requirements of the Joint Commission on Accreditation of Hospitals, audits were conducted relative to the medical care of patients with the diagnosis of ectopic pregnancy over a two-year period (July 1, 1974, through June 30, 1976). The records of all patients with a proven diagnosis of ectopic pregnancy within that stated time interval were retrieved and reviewed.

This study covered two community general hospitals, Deaconess and Missouri Baptist, in the metropolitan St. Louis area. Each hospital had a capacity of 500 beds and cooperated in a joint residency program in obstetrics and gynecology. Deaconess Hospital is located on the western edge of the city of St. Louis, while Missouri Baptist is located farther west in St. Louis County.

The population served varied from non-private patients living in the inner city of St. Louis to private patients from the more affluent areas of St. Louis County. In addition, there were both private and non-private patients from surrounding areas of Illinois and small communities to the west and south of St. Louis.

### Results

During the two-year period reviewed, there was a total of 5,232 deliveries in the two hospitals with the distribution noted in Table 1. The same table displays the 52 ectopic pregnancies that occurred. This gave an incidence of about one per 100 deliveries, with a difference noted between hospitals.

All patients had surgery with the diagnosis confirmed by histological evidence. There were no deaths. Other general findings relative to patient profiles, symptomatology, surgical techniques, etc., were not remarkable enough to warrant statistical analysis or further exposition. There were, however, unique clinical findings in some individuals worthy of note:

*Case 1.* A 19-year-old white female, Para 0. Her last menstrual flow occurred seven weeks earlier. When she was admitted through the emergency room, laboratory studies revealed a dropping hematocrit and a positive culdocentesis. Laparotomy revealed 3000 ml. of blood in the peritoneal cavity. The patient had a smooth recovery following left salpingectomy for a ruptured ectopic pregnancy. She received blood transfusions and Rhogam. She delivered a healthy son 11 months later at term and a healthy daughter at term some 28 months after her surgery.

*Case 2.* This 41-year-old black female was seen by a general surgeon who noticed a mass extending up to her umbilicus and referred her to the Prenatal Clinic. Her last menstrual flow was indefinite: however, she had had spotting for the past four months. Her only pregnancy, at age 21, ended in a spontaneous abortion at seven weeks' gestation. During the past 20 years, no birth control was practiced: however, no pregnancies had occurred. The patient entered the hospital for evaluation. The cervix was firm and pink, but the uterus could not be outlined as such. There was a large pelvic mass extending from just to the right of the mid line to the left pelvic wall and from the symphysis to the umbilicus. It appeared fixed, non-tender, and irregular in contour. There was extensive pressure on the rectum. Despite a positive test for chorionic

**TABLE 1**
**1974 - 1976**

| | DH | MBH | TOTAL |
|---|---|---|---|
| Ectopic Pregnancies | 25 | 27 | 52 |
| Deliveries | 1,962 | 3,270 | 5,232 |
| Incidence | 1/78 | 1/120 | 1/100 |

*This paper was written while the authors were members of the staffs, Department of Obstetrics and Gynecology, of Deaconess Hospital and Missouri Baptist Hospital, both in St. Louis, Missouri.

gonadotropin, the preoperative diagnosis favored was left ovarian tumor, possibly a non-gestational trophoblastic tumor.

Laparotomy revealed a degenerating abdominal pregnancy with a dead fetus of about 17 weeks' size. A total abdominal hysterectomy and bilateral salpingo-oophorectomy was done. In addition to the abdominal pregnancy she had fibromyoma of the uterus and a Brenner tumor in the right ovary. She had an uneventful convalescence and subsequently was working as a bus driver.

*Case 3.* This 21-year-old white female, Para 0, was seen in the Gynecology Clinic because of minimal, irregular, vaginal bleeding and vague, lower, abdominal pain, especially in the right lower quadrant. Her last menstrual flow could not be ascertained. A surgical consult did not believe low grade appendicitis was a problem. The patient subsequently underwent uterine curettage with a diagnosis of endometrium showing decidual reaction and chronic endometritis. The patient did not return to the clinic for her postoperative evaluation. Six weeks after her curettage she entered the same hospital under the care of a general surgeon. The diagnosis preoperatively was appendiceal abscess.

Laparotomy disclosed a degenerative right tubal pregnancy, organizing hematosalpinx, chronic salpingitis and organizing hematoma of the omentum. The appendix was unremarkable on histological examination. The patient recovered uneventfully after her surgery, which included right salpingectomy, partial omentectomy, and incidental appendectomy.

### Left Tubal Pregnancy

*Case 4.* This 17-year-old black female was seen in the Medical Clinic complaining of weakness and vague lower abdominal discomfort. Little concern was expressed over the fact she was one week past her expected menstrual flow. She was admitted to the Medical Service, and extensive studies were carried out in regard to a severe anemia and possible hemoglobinopathy. After one week she went home on hematinics.

Ten days later this patient returned to the emergency room with severe vomiting, vaginal bleeding for one week, left lower quadrant pain and tenderness. A culdocentesis was negative. Laparoscopic examination revealed a hemorrhagic left pelvic mass consistent with an ectopic pregnancy.

Laparotomy revealed a left tubal pregnancy which had ruptured to produce an intraligamentous hematoma into the left broad ligament. The patient recovered after a left salpingo-oophorectomy, evacuation of the hematoma and blood transfusions.

*Case 5.* A 23-year-old black female, Para 2, whose last menstrual flow was eight weeks earlier, passed clots and tissue after one day of bleeding. Her uterus was six to eight weeks' size. She had a hemoglobin of 12.3 grams and a hematocrit of 37 per cent. A curettage revealed products of conception consistent with an incomplete abortion. She went home the first postoperative day.

Two days later she was brought to the emergency room in shock and with severe lower abdominal pain. Her hemoglobin was eight grams with a hematocrit of 30 per cent. Culdocentesis was positive. Laparotomy revealed a hemoperitoneum of 3000 ml. of blood and a ruptured right tubal pregnancy. She had a right salpingectomy, and receiveed 2000 ml. of blood. Her recovery was uneventful.

### Ruptured Right Tubal Pregnancy

*Case 6.* A 27-year-old white female, Para 3, had a laparoscopic sterilization performed, on an ambulatory basis at another hospital, about three and one-half weeks after her last menstrual flow and obviously in the luteal phase of her cycle. Three days later she was brought to the emergency room in shock. Culdocentesis revealed fresh blood. A laparotomy disclosed 2500 ml. of blood in the peritoneal cavity and a ruptured right tubal pregnancy. A review of the laparoscopy operative report documented the physician note, "a bluish area," in the right uterine tube which he ascribed to "either endometriosis or a hematoma."

*Case 7.* This 25-year-old white female, Para 1, had her last menstrual flow seven weeks prior to arriving in the emergency room, in shock, with a history of lower abdominal pain. Fresh blood was obtained at culdocentesis. Laparotomy revealed a ruptured left tubal pregnancy. There was congenital absence of the right uterine tube and right ovary. A left tuboplasty was carried out. Recovery was uneventful. An intravenous pyelogram revealed a normal urinary tract.

*Case 8.* A 27-year-old white female, Para 2, had trouble with an intrauterine device relative to spotting, and vague discomfort in the lower abdomen. About two weeks earlier her gynecologist removed the device at an office visit. Shortly afterwards, she had what she considered a normal menstrual flow.

She was brought to the emergency room following a syncopal attack at home. Her hemoglobin was 7.5 grams and culdocentesis revealed fresh blood. She was admitted to the hospital.

treated conservatively, and transfused back to 12.5 grams over the next four days. She was sent home at this point. The next day, while preparing to go out for a holiday dinner, she again had a syncopal attack and was rushed back to the emergency room. Her hemoglobin was now 7.5 grams. Emergency laparotomy disclosed a ruptured left tubal pregnancy with 3000 ml. of blood in the peritoneal cavity. Recovery was uneventful.

*Case 9.* This 20-year-old black female, Para 0, was brought to the emergency room in shock following severe abdominal pain. Culdocentesis revealed fresh blood. Laparotomy revealed ruptured right tubal pregnancy and 2000 ml. of blood in the peritoneal cavity. She recovered following a right salpingectomy. Five months later this patient was brought to the emergency room in the same condition. After a positive culdocentesis, a laparotomy disclosed a hemoperitoneum of 2500 ml. and a ruptured left tubal pregnancy. She recovered following a left salpingectomy.

*Case 10.* This obese, 20-year-old, white female, Para 0, was brought to the emergency room because of severe abdominal pain and syncope. She had amenorrhea of seven weeks' duration. Culdocentesis recovered fresh blood. Laparotomy revealed bilateral ruptured ectopic pregnancies associated with a bicornuate uterus and 2500 ml. of blood in the peritoneal cavity. Tubal salvage could not be carried out. The patient recovered following a bilateral salpingectomy.

**TABLE 2**

**Ectopic Pregnancy**

| Author | Location | Incidence |
|---|---|---|
| Douglas[3] | Jamaica | 1/28 |
| Skulj[4] | Yugoslavia | 1/45 |
| Bobrow & Bell[5] | Harlem Hospital | 1/64 |
| Helvacioglu *et al.*[6] | Chicago Lying-In Hospital | 1/72 |
| Clark & Jones[7] | Freedman's Hospital | 1/84 |
| Breen[8] | St. Barnabas Medical Center | 1/87 |
| This Study | St. Louis | 1/100 |
| Webster *et al.*[9] | Charity Hospital (New Orleans) | 1/116 |
| Franklin *et al.*[10] | Grady Memorial Hospital | 1/118 |
| Fielding *et al.*[11] | Boston City Hospital | 1/119 |
| Kallenberger *et al.*[12] | Oklahoma City | 1/124 |
| Pritchard & Macdonald[13] | Parkland Memorial Hospital | 1/125 |
| Harralson *et al.*[14] | U. of Kentucky Medical Center | 1/230 |
| Feeney[15] | Ireland | 1/1000 |

**Discussion**

The generally accepted incidence of ectopic pregnancy is one per 200 pregnancies.[2] The rate may vary according to locale and is influenced by socio-economic, racial, and geographic factors. Reported series are summarized in Table 2 along with this study.[3-15]

The incidence of ectopic pregnancy appears to be increasing. There obviously is a reduction of deliveries because of voluntary family planning. Some of the methods used to accomplish this (i.e., intrauterine devices) do not prevent ectopic pregnancy as effectively as they do intrauterine pregnancy.[16-18] In addition, there is evidence of a rising incidence of veneral diseases, especially gonorrhea. Despite effective antibiotic therapy, there still may be tubal sequellae conducive to ectopic pregnancy.[6,12]

The individual case histories cited illustrate the variety of conditions often encountered in such patients. *Case One* had two uneventful pregnancies after her ectopic pregnancy. *Case Nine*, with two ectopic pregnancies in five months, lost her ability to reproduce. *Case Seven* required conservative surgery to preserve her only uterine tube, although her chances for a repeat ectopic pregnancy are increased.[19,20]

*Cases Two, Three* and *Four* displayed diagnostic problems resolved by definitive surgery. *Case Five* had both an intrauterine and extra-uterine pregnancy, while *Case 10* had a bilateral tubal pregnancy associated with a bicornuate uterus. Such occurrences have been documented previously.[11,21-28]

*Case Six* had elective sterilization carried out during the luteal phase of her cycle. She obviously was pregnant already, and perhaps longer than her menstrual flow pattern suggested. *Case Eight* represents a most unusual therapeutic approach to this life-threatening situation. Fortunately, the patient survived two syncopal attacks and what could have been a holiday tragedy.

The preceding findings relative to individual patients epitomize the quote: "The physician who has ectopic pregnancy on the brain will rarely fail to diagnose it when it exists. On the other hand, one who is not alert to its possibility will meet with many surprises which greater care could have avoided."[24]

**Summary**

All ectopic pregnancies occurring in two community general hospitals over a two-year period were reviewed utilizing a medical audit technique for information retrieval. The incidence derived

has been compared with that reported in other publications. One can only conclude that ectopic pregnancy remains a threat to the life of every woman during her reproductive years and a challenge to the diagnostic acumen of the physician.

### References


1. Malt SH: Outcome audit techniques used to write medical articles. *Mo Med* 74:639-642, 1977.

2. Bigelow B: Chapter 30—Abnormalities and diseases of the placenta, membranes, and umbilical cord, in Blaustein A (ed): *Pathology of the Female Genital Tract*, New York, Springer-Verlag, 1977.

3. Douglas CP: Tubal ectopic pregnancy. *Br Med J* 2:838-841, 1963.

4. Skulj V: Significance of tubal pregnancy in the reproductive life of women. *Am J Obstet Gynecol* 80:278-283, 1960.

5. Bobrow ML, Bell GH: Ectopic pregnancy: A 16-year survey of 905 cases. *Obstet Gynecol* 20:500-505, 1962.

6. Helvacioglu A, Long EM Jr, Yank SL: Ectopic pregnancy: An eight-year review. *J Reprod Med* 22:87-92, 1979.

7. Clark JFJ, Jones SA: Advanced ectopic pregnancy. *J Reprod Med* 14:30-33, 1975.

8. Breen JL: A 21-year survey of 654 ectopic pregnancies. *Am J Obstet Gynecol* 106:1004-1019, 1970.

9. Webster JD, Barclay DL, Fischer CK: Ectopic pregnancy: 17-year review. *Am J Obstet Gynecol* 92:23-34, 1965.

10. Franklin EW III, Ziederman AM, Laemmle P: Tubal ectopic pregnancy: Etiology and obstetric and gynecology sequellae. *Am J Obstet Gynecol* 117:220-225, 1973.

11. Fielding WL, Kennedy RK, Gillies RW: Extrauterine pregnancy: Statistical review of 160 cases. *Obstet Gynecol* 26:702-707, 1965.

12. Kallenberger DA, Ronk DA, Jumerson GK: Ectopic pregnancy: A 15-year review of 160 cases. *South Med J* 71:758-763, 1978.

13. Pritchard J, MacDonald PC: Chapter 21 — Ectopic pregnancy, in *Williams' Obstetrics*, ed 15, New York, Appleton-Century-Croft, 1976.

14. Harralson JD, VanNagell JR, Roddick JW Jr: Operative management of ruptured tubal pregnancy. *Am J Obstet Gynecol* 115:995-997, 1973.

15. Feeney JR: Disturbed ectopic pregnancy. *Irish J Med Sci* 6:213-223, 1960.

16. Lehfeldt H, Tietze C, Gorstein F: Ovarian pregnancy and the intrauterine device. *Am J Obstet Gynecol* 108:1005-1009, 1970.

17. Vessey MP, Doll R, Johnson B, Petro R: Outcome of pregnancy in women using an intrauterine device. *Lancet* 1:495-498,1974.

18. Seward PN, Israel R, Ballard CA: Ectopic pregnancy and intrauterine contraception — A definite relationship. *Obstet Gynecol* 122:520-524, 1975.

19. Hallatt JC: Repeat ectopic pregnancy: A study of 123 consecutive cases. *Am J Obstet Gynecol* 122:520-525, 1975.

20. Schoen JA, Nowak RJ: Repeat ectopic pregnancy: A 16-year clinical survey. *Obstet Gynecol* 45:542-546, 1975.

21. Winer AE, Bergman WD, Fields C: Combined intra- and extrauterine pregnancy. *Am J Obstet Gynecol* 74:170-178, 1957.

22. Brody S, Stevens FL: Combined intra- and extrauterine pregnancy. *Obstet Gynecol* 21:128-132, 1963.

23. Evans GE, Gorjanes E: Bilateral ectopic gestation. *Am J Obstet Gynecol* 64:444-447, 1952.

24. Novak ER, Jones GS, Jones HW Jr: *Novak's Textbook of Gynecology*, ed 9, Baltimore, William and Wilkins, 1975.

# Causes Of Perinatal Mortality In A Community Hospital: Report Of A Prospective Study, 1975 To 1978

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*From 1975 to 1978, causes of all perinatal deaths at the Charleston (West Virginia) Area Medical Center, Memorial Division, were studied in a prospective manner. There were 16,177 deliveries during this period. It is recommended that, in order to reduce the perinatal death rate further, all prenatal patients should be screened for high-risk factors. Patients at risk should be monitored carefully with the currently available methods of maternal-fetal surveillance during the pre- and intrapartum period.*

If we are to make significant reductions in fetal and neonatal deaths in our region of service, we first must clearly define the leading causes of these deaths. Naeye,[1] Manniello and Farrell,[2] and Harper *et al.*[3] have described causes of perinatal deaths from retrospective reviews of patient records. Other reports [4-7] also indicate that the causes of fetal and neonatal deaths vary with the period of review, patient population, quality of medical care, and the geographic area, among other factors. Therefore, in order to reduce the preventable causes of perinatal deaths, we first must identify them on a regional basis and then plan appropriate steps to eliminate them.

This paper describes the results of a prospective study of the causes of perinatal deaths, rather than a retrospective review of the death certificates or patient charts long after the event.

The Charleston (West Virginia) Area Medical Center (CAMC) was formed in 1972 by merger of three community hospitals. The obstetrical services were consolidated at the Memorial Division of CAMC. The new and modern obstetrical unit was complemented with well-equipped and well-staffed normal and intensive care nurseries. The CAMC obstetric unit is a tertiary care facility which serves a major part of southern West Virginia. It is affiliated with the Charleston Division of the West Virginia University Medical Center and provides graduate and undergraduate training in obstetrics.

About 75 per cent of the deliveries are on the private service and 25 per cent on the resident service. All labor patients, on both services, are followed by the residents. Almost all the private patients are delivered by board-certified or board-eligible obstetricians. The resident service is supervised by the attending and the full-time faculty. More than 90 per cent of patients delivered are Caucasians. The predominant anesthesia for vaginal delivery is Saddle block. Almost all cesarean sections were done under general anesthesia.

### Materials and Methods

From January, 1975, to December, 1978, careful records were kept of all the fetal and neonatal deaths at the CAMC Memorial Division. Soon after a perinatal death, a summary was prepared containing relevant information from the mother's history, physical examination, prenatal course and, in case of neonatal death, neonatal course. The placenta was examined by the obstetrician and gross abnormalities noted. Pathologic examination of the placenta and autopsies were obtained when possible. From this information the most likely prime cause or the associated cause of death was assigned.

The prime cause of death is defined as the condition which initiated events leading to the perinatal death. For example, the immediate cause of a fetal or a neonatal death may be asphyxia; however, asphyxia may be caused by different maternal or fetal/neonatal conditions. In this analysis, an attempt is made to define the maternal and fetal/neonatal conditions leading to asphyxia and death. Thus, we can focus on the preventable causes of such deaths.

On occasion, a prime cause of death was not apparent; however, a very significant associated condition was present. This associated condition was designated as the most likely associated cause of death. In the absence of an apparent prime cause of death, recognition of the associated cause may be important in the prevention of some of these perinatal deaths.

Fetal death is defined as death of a fetus of 20 weeks' or more gestation or weighing at least 500 gm. Neonatal death is death of a liveborn fetus within 28 days of birth. Fetal death rate is the number of fetal deaths per 1,000 births.

Neonatal death rate is the number of neonatal deaths per 1,000 live births. Perinatal death rate is the number of fetal and neonatal deaths per 1,000 births.

Newborns transferred from other hospitals, voluntary interruptions of pregnancies, and babies weighing less than 500 gm are not included in this report.

### Results

From January 1, 1975, to December 31, 1978, there were 16,177 deliveries, 143 fetal deaths and 136 neonatal deaths at CAMC. Some features of the obstetric service are given in Table 1.

Of the 143 fetal deaths, 112 (78 per cent) were antepartum and 31 (22 per cent), intrapartum. Tables 2 and 3 show causes of antepartum and intrapartum fetal deaths in all fetuses and in fetuses weighing more than 1,500 gm. Table 4 shows the causes of all neonatal deaths and deaths in neonates weighing more than 1,500 gm. Table 5 shows the distribution of fetal and neonatal deaths by weight. Table 6 shows the perinatal death rate from 1975 to 1978 and the mean death rate on the private and the resident service. The perinatal mortality rate in West Virginia dropped from 25.4 in 1975 to 21.2 in 1978. Autopsy rate on perinatal deaths was 55 per cent. The cesarean section rate increased from 8.9 per cent in 1975 to 15.2 per cent in 1978.

Overall incidence of teenage deliveries (19 years or younger) at CAMC is 20 per cent; however, 25 per cent of perinatal deaths occurred in teenage mothers. In women 30 years or younger perinatal deaths were equally divided between fetal and neonatal deaths. After 30 years of age, there were more fetal than neonatal deaths.

### Discussion

Different authors have described somewhat different leading causes of fetal and neonatal deaths (Table 7). The differences probably are due to the method and the period of review, the type and geographic location of the population studied, and the quality of medical care, among other factors. At CAMC the leading causes of fetal death were: unknown, abruptio placentae, and congenital anomalies; of neonatal death, prematurity, congenital anomalies and abruptio placentae.

By analyzing the causes of antepartum and intrapartum fetal deaths close to the event, it

**TABLE 1**

**Profile of Patients Delivered at the Charleston Area Medical Center, 1975-1978**

| *Patients Delivered 16,177* | *Per Cent* |
|---|---|
| Primigravidas | 41.92 |
| Spontaneous Delivery | 32.82 |
| Forceps Delivery | 53.60 |
| Vacuum Extraction | 1.47 |
| Cesarean Section | 11.95 |
| Live Births < 2.5 kg | 7.33 |
| > 4.0 kg | 10.14 |

**TABLE 2**

**Causes of Antepartum and Intrapartum Fetal Deaths**

| *Causes* | *Antepartum* No. | *Per Cent* | *Intrapartum* No. | *Per Cent* |
|---|---|---|---|---|
| *Prime Causes* | | | | |
| Unknown | 50 | 44.63 | 3 | 9.67 |
| Abruptio Placentae | 17 | 15.17 | 4 | 12.90 |
| Congen. Anom. (CNS) | 8 | 7.14 | 11 | 35.48 |
| Congen. Anom. (Multiple) | 5 | 4.46 | 2 | 6.45 |
| Cord Accident | 4 | 3.57 | 3 | 9.67 |
| Miscellaneous | 3° | 2.67 | 2°° | 6.45 |
| *Associated Causes* | | | | |
| Preeclampsia/Hypertension | 10 | 8.92 | 2 | 6.45 |
| Diabetes | 9 | 8.03 | – | – |
| Prem. Rupture of Memb. | 4 | 3.57 | 1 | 3.22 |
| I. U. G. R. | 1 | 0.89 | 2 | 6.45 |
| Utero-placental insufficiency | 1 | 0.89 | 1 | 3.22 |
| TOTAL | 112 | 100.00 | 31 | 100.00 |

° One each due to twin-to-twin transfusion, auto accident and rupture of classical cesarean section scar.

°° One each due to intrauterine infection and idiopathic fetal hydrops.

I.U.G.R.: Intrauterine Growth Retardation. CNS: Central Nervous System.

**TABLE 3**

**Causes of Antepartum and Intrapartum Fetal Deaths in Fetuses Weighing More than 1,500 GM.**

| *Causes* | *Antepartum* No. | *Per Cent* | *Intrapartum* No. | *Per Cent* |
|---|---|---|---|---|
| *Prime Causes* | | | | |
| Unknown | 37 | 56.06 | 2 | 10 |
| Abruptio Placentae | 10 | 15.15 | 1 | 5 |
| Congen. Anom. (CNS) | 2 | 3.03 | 6 | 30 |
| Congen. Anom. (Multiple) | 2 | 3.03 | 2 | 10 |
| Cord Accident | 3 | 4.54 | 2 | 10 |
| Miscellaneous | 2° | 3.03 | 2°° | 10 |
| *Associated Causes* | | | | |
| Preeclampsia/Hypertension | 5 | 7.57 | 2 | 10 |
| Diabetes | 5 | 7.57 | – | – |
| I.U.G.R. | – | – | 2 | 10 |
| Utero-Placental insufficiency | – | – | 1 | 5 |
| TOTAL | 66 | 100.00 | 20 | 100 |

° One each due to twin-to-twin transfusion and rupture of classical cesarean section scar.

°° One each due to intrauterine infection and idiopathic fetal hydrops.

was possible to assign the most probable cause in 63 per cent of all fetal deaths. This figure can be improved further by close scrutiny of the prepartum and intrapartum factors.

Abruptio placentae was a significant cause of both the fetal and the neonatal deaths. About half the time this was associated with maternal preeclampsia/hypertension. Since preeclampsia/hypertension also was a significant associated cause of perinatal deaths, this condition should be recognized early and managed actively.

**TABLE 4**

**Causes of All Neonatal Deaths and Deaths in Neonates Weighing More Than 1,500 GM.**

| *Causes* | *All Neonatal Deaths* | | *Neonatal Deaths Weighing More Than 1,500 GM.* | |
|---|---|---|---|---|
| | *No.* | *Per Cent* | *No.* | *Per Cent* |
| *Prime Causes* | | | | |
| Prematurity | 81 | 59.55 | 11 | 19.64 |
| Congen. Anom. (Multiple) | 23 | 16.91 | 21 | 37.5 |
| Congen. Anom. (CNS) | 6 | 4.41 | 6 | 10.74 |
| Abruptio Placentae | 4 | 2.94 | 2 | 3.57 |
| Cord Accident | 3 | 2.20 | 2 | 3.57 |
| RDS | 2 | 1.47 | 2 | 3.57 |
| Sepsis (neonatal) | 1 | 0.73 | 1 | 1.78 |
| Sepsis (chorio-amnionitis) | 1 | 0.73 | 1 | 1.78 |
| *Associated Causes* | | | | |
| Preeclampsia/Hypertension | 6 | 4.41 | 1 | 1.78 |
| Intrapartum Fetal Distress | 5 | 3.67 | 5 | 8.92 |
| Birth Trauma | 3 | 2.20 | 3 | 5.35 |
| I.U.G.R. | 1 | 0.73 | 1 | 1.78 |
| TOTAL | 136 | 100.00 | 56 | 100.00 |

**TABLE 5**

**Fetal and Neonatal Deaths by Weight**

| *Weight* | *Fetal Deaths* | | | | *Neonatal Deaths* | |
|---|---|---|---|---|---|---|
| | *Ante Part.* | *Intra Part.* | *No.* | *Per Cent* | *No.* | *Per Cent* |
| 1,000 gm. or less | 25 | 7 | 32 | 22.37 | 57 | 41.91 |
| 1,000 to 1,500 gm. | 21 | 4 | 25 | 17.48 | 23 | 16.91 |
| 1,501 to 2,000 gm. | 16 | 1 | 17 | 11.88 | 16 | 11.76 |
| 2,001 to 2,500 gm. | 16 | 4 | 20 | 13.98 | 8 | 5.88 |
| 2,501 gm. or more | 34 | 15 | 49 | 34.26 | 32 | 23.52 |
| TOTAL | 112 | 31 | 143 | 100.00 | 136 | 100.00 |

Congenital anomalies also were an important cause of perinatal deaths. They were the leading cause of intrapartum fetal deaths and neonatal deaths in babies weighing more than 1,500 gm. Worton[8] estimated about five per cent of the fetal deaths were due to chromosomal anomalies.

Prematurity, and its consequences, was the leading cause of neonatal deaths. In the vast majority of cases, prematurity was the result of premature labor. Although causes of premature labor are varied and frequently poorly understood, they are related to the antepartum conditions and events.

The ratio of antepartum to intrapartum fetal deaths and perinatal mortality rate has not changed significantly over the past four years. Sixty per cent of the fetal deaths and 41 per cent of the neonatal deaths occurred in babies weighing more than 1,500 gm. A fetus weighing 1,500 gm or greater has a good chance of surviving and developing normally in a good intensive care nursery.

It would appear that by identifying the high-risk prenatal patient early and by providing her with the appropriate level and quality of obstetrical care, perinatal death rate can be reduced significantly. There is an obvious need to allocate a proportionate amount of efforts and resources to the antepartum screening and surveillance of the high-risk patient.

### Summary

From 1975 to 1978, causes of all perinatal deaths at the Charleston Area Medical Center, Memorial Division, were studied in a prospective manner. There were 16,177 deliveries during this period. Perinatal mortality rate was similar in primigravidas and multigravidas, but was

**TABLE 6**

**Perinatal Death Rate at CAMC, 1975-1978**

| | 1975 NO. | 1976 NO. | 1977 NO. | 1978 NO. | 1975-78 MEAN DEATH RATE PRIVATE SERV. | 1975-78 MEAN DEATH RATE RESIDENT SERV. |
|---|---|---|---|---|---|---|
| Fetal Death | 35 (5°) | 34 | 33 (4°) | 41 (8°) | 8.57 (8.23°°) | 9.59 (6.56°°) |
| Neonatal Death | 27 (6°) | 40 (3°) | 27 (6°) | 42 (11°) | 6.38 (6.13°°) | 14.04 (8.65°°) |
| Perinatal Death Rate | 17.08 (14.03°°) | 19.54 (18.75°°) | 13.51 (9.68°°) | 18.44 (14.22°°) | 14.95 (14.36°°) | 23.63 (15.21°°) |

° Referred or without prenatal care patients

°° Perinatal death rate excluding referred or without prenatal care patients

**TABLE 7**

**Causes of Fetal and Neonatal Deaths Reported by Different Authors**

| Naeye,[1] 1959-1966 | | Ott *et al.*[4] 1969-1975 | | | | Manniello & Farrell,[2] 1968-1974 |
|---|---|---|---|---|---|---|
| FETAL DEATHS | NEONATAL DEATHS | FETAL DEATHS | | NEONATAL DEATHS | | NEONATAL DEATHS |
| | | MUNICIPAL HOSP. | PRIVATE HOSP. | MUNICIPAL HOSP. | PRIVATE HOSP. | |
| Unknown | Amn. Fluid Infection | Abruptio Placentae | Abruptio Placentae | Resp. Distress Syndrome | Resp. Distress Syndrome | Hyaline Memb. Disease/Resp. Distress Syndrome |
| Abruptio Placentae | Prem. Rupt. of Memb. | Immaturity | Cord Problems | Immaturity | Congen. Anom. | Immaturity |
| Amn. Fluid Infection | Unknown | Anoxia | Erythroblastosis | Congen. Anom. | Immaturity | Asphyxia |
| Large Placen. Infarcts | Congen. Anom. | Congen. Anom. | Immaturity | Intracranial Hemorrhage | Erythroblastosis | |
| Congen. Anom. | Abruptio Placentae | | | | | |

higher in teenage mothers. Mean gross perinatal mortality rate was 17.24. Fetal and neonatal death rates were about equal. Seventy-eight per cent of the fetal deaths were antepartum and 22 per cent intrapartum.

A most likely prime cause or an associated cause of death could be assigned to 63 per cent of fetal deaths and 100 per cent of neonatal deaths. Leading causes of fetal deaths were: unknown (37 per cent), congenital anomalies (18 per cent) and abruptio placentae (15 per cent). Leading causes of neonatal deaths were: prematurity (60 per cent) and congenital anomalies (21 per cent).

It is recommended that, in order to reduce the perinatal death rate further, all prenatal patients should be screened for high-risk factors. Patients at risk should be monitored carefully with the currently available methods of maternal-fetal surveillance during the pre- and intrapartum period.

**References**


1. Naeye RL: Causes of perinatal mortality in the U. S. Collaborative perinatal project. *JAMA* 238:228, 1977.

2. Manniello RL, Farrell PM: Analysis of United States neonatal mortality statistics from 1968 to 1974, with specific reference to changing trends in major causalities. *Am J Obstet Gynecol* 129:667, 1977.

3. Harper RG, Sokal MM, Sokal S, Mastrota VF, Davis JG: The high-risk perinatal registry. A systematic approach for reducing perinatal mortality. *Obstet Gynecol* 50:264, 1977.

4. Ott WJ, Ostapowicz F, Meurer J: Analysis of variables affecting perinatal mortality. St. Louis Hospital, 1969-1975. *Obstet Gynecol* 49:481, 1977.

5. Reeves BD, Anderson ER: Perinatal mortality rate of a community hospital, 1956-1975. *Am J Obstet Gynecol* 128:677, 1977.

6. Owen JD: North-East Essex perinatal mortality survey—1971 to 1975. *Brit J Obstet Gynecol* 84:412, 1977.

7. Franklin RW: Perinatal mortality rates: A fourteen year survey in a metropolitan community hospital. *Am J Obstet Gynecol* 119:297, 1974.

8. Worton RG: Chromosome abnormalities: A major cause of birth defects, stillbirth and spontaneous abortion. *Canad Med Assoc J* 117:849, 1977.

# Medical Grand Rounds

**From the West Virginia University Medical Center**

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## Diagnosis And Treatment Of Symptomatic Gastroesophageal Reflux

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*Esophageal reflux is a common clinical condition manifested by recurrent episodes of pyrosis, regurgitation and dysphagia. Clinical symptoms result from inadequate protection of the esophagus from reflux, impairment of the defense factors of the esophagus, and the material refluxed. Clinical evaluation is carried out with barium esophagogram, endoscopy, mucosal biopsy, acid perfusion and reflux testing, and most recently, scintiscanning.*

*Medical therapy includes dietary measures, control of acid secretion by the stomach, avoidance of medication which interferes with the normal lower esophageal sphincter protective action, and postural changes to increase the ability of the esophagus to clear noxious stimuli.*

*Surgical therapy consists of a fundoplication procedure to prevent reflux, and is used when medical therapy fails and for the complications of reflux.*

ESOPHAGEAL reflux is a common occurrence in the normal human, especially after meals and with belching. It becomes clinically significant when it produces symptoms, particularly obstruction, bleeding, pain and pulmonary problems. Knowledge of its pathophysiology has been expanded in the last 10 years, and this paper will review diagnosis and management of the disorder.

### Clinical Presentation

Reflux occurs normally in all humans, but, because of the ability of the esophagus to clear the refluxed material rapidly, clinical symptoms do not develop. The most common symptom is pyrosis (heartburn). Characteristically, this is more marked at night, upon stooping — particularly following a large meal, following the ingestion of substances such as coffee, alcohol, citrus drinks, fried and fatty foods, and with smoking. Coffee, fried and fatty foods, tobacco and alcohol produce pyrosis by relaxing the lower esophageal sphincter. Spicy citrus drinks irritate an already-inflamed esophageal mucosa.

Chronic pulmonary complaints result from regurgitation of gastric contents with subsequent aspiration into the lungs. Recurrent pneumonias can be a symptom of esophageal reflux. Dysphagia is common. This can occur from esophageal stricture or it may be a manifestation of esophageal motor dysfunction secondary to esophagitis.

Pain of peptic esophagitis classically is retrosternal. It may be referred to the back or the shoulders. It can be confused with other chest pain such as angina or diffuse esophageal spasm. Differentiation is made by means of history and laboratory studies.

### Protective Mechanisms

Protective mechanisms are present to protect the esophagus from reflux. These include the lower esophageal sphincter (LES) which normally remains contracted until swallowing, the acid-clearing mechanism of tertiary contractions of

the esophagus, the acute angle at which the esophagus enters the stomach (angle of His), the rosette present at the distal esophageal gastric junction, the intra-abdominal portion of the esophagus, and the phrenoesophageal ligaments. Salivary secretions which are alkaline also may participate by neutralizing acid refluxed into the esophagus. Factors that injure the esophageal mucosa include the acid of the stomach, pepsin in the gastric secretions, bile salts and pancreatic enzymes.

Several clinical conditions have been associated with increased esophageal reflux. Scleroderma destroys the LES, thereby allowing free reflux. The smooth muscle portion of the lower two thirds of the esophagus also is affected, thus obliterating tertiary waves. While these are not of tremendous importance when the patient is erect because of gravity, they are a major mechanism when the patient is supine for protecting the esophagus from refluxed material.

Pregnancy long has been known to be associated with pyrosis. This at first was felt to be due to reflux of gastric contents because of the enlarging uterus. Recent evidence, however, has shown that progesterone decreases pressure in the LES, allowing free reflux into the esophagus.

Vagotomy, either surgical or as a result of vagus blockade from the administration of anticholinergic agents, has been associated with reflux.

Some infants who fail to thrive have a transient defect in the LES, called achalasia, which allows GE reflux.

### Diagnostic Techniques

Laboratory measures recently have been developed to define better the presence of reflux and its effect on the esophageal mucosa. The Bernstein test is utilized to reproduce symptoms of reflux by instilling acid directly into the esophagus. The test is performed by placing a nasogastric tube five cm. above the esophageal-gastric junction. The tube is connected by means of a Y-connector to a bottle of normal saline and one of 0.1 N hydrochloric acid. The normal saline is instilled initially into the esophagus for 15 minutes. The patient is asked if this infusion reproduces the complaints of reflux.

Next, the hydrochloric acid is instilled. If complaints occur, this infusion is then discontinued and the saline is infused again. If symptoms disappear with the infusion of saline, and if hydrochloric acid, but not saline, produces the symptoms, this is felt to be strong evidence in favor of acid reflux into the esophagus as the basis for the patient's complaints. If all the substances produce symptoms, the test suggests that factors other than acid are responsible for the complaints.

Reflux can be measured by placing a small pH electrode five cm. above the gastroesophageal junction. The measurement of spontaneous reflux over a 24-hour period by this technique has been particularly beneficial in some patients in defining the basis for esophagitis. Another method, somewhat less elaborate, is the Tuttle test. This test is performed by placing three hundred ml. of 0.1 N hydrochloric acid into the stomach and measuring reflux of this with a pH electrode placed five cm. above the LES. In addition to spontaneous reflux, LES competence is measured by having the patient stoop, bend, do leg-lifts and the Valsalva and Müller maneuvers with the pH electrode in place.

### Radiologic Procedures

The barium swallow and upper GI series long have been used as studies of esophageal reflux. These define not only reflux, but some of the complications of reflux such as esophageal stricture. The water syphonage test consists of placing the patient in the right lateral decubitus position, instilling barium into the stomach and then observing under the fluoroscope whether reflux occurs with swallowing. Physiologically, this is not a valid test because swallowing normally produces relaxation of the LES; if barium is in the fundus it can flow easily through the relaxed sphincter, giving a false positive test.

The gastroesophageal scintiscan, a tubeless isotope technique which demonstrates reflux as efficiently as the pH probe, has been developed recently. Three hundred ml. of 99m Tc sulfur colloid in acidified orange juice is ingested while the gamma camera is focusd on the stomach and the distal area of the esophagus. Multiple films subsequently are obtained, and the amount of Tc sulfur colloid refluxed into the esophagus is determined by a computer attached to the gamma camera. During recording, the LES is stressed by the use of an external abdominal binder.

### Endoscopy

Endoscopy is helpful in delineating the presence of esophagitis or a stricture as well as ruling out other causes for stricture such as neoplasm. Biopsies probably are taken better with a suction biopsy instrument than the punch biopsy implement furnished with the endoscope because of the small size of the biopsies obtained with the latter. In esophagitis there is pro-

liferation of cells at the base of the esophageal mucosa with resultant thickening of the basal cell layer. The basal papillae become elongated and extend closer to the surface. Because these papillae contain nerves and blood vessels, exposure to acid may account for the pain and bleeding that occur in esophagitis. Round-cell infiltration, while not common, may occur, and ulceration sometimes can be demonstrated on microscopic sections. It is important that biopsies be obtained at least five cm. above the LES because changes similar to these have been found in normals at the gastro-esophageal junction.

### Motor Evaluation

Confirmation of LES dysfunction has been obtained by esophageal motility testing using a triple lumen perfusion catheter system. Unfortunately, this is not too helpful clinically, for, while most normal people have an LES pressure greater than 10 millimeters of mercury, there are some who have lower sphincter pressures with no evidence of reflux.

Esophageal motor function also can be evaluated by this study. This may be helpful in defining some diseases such as scleroderma. Instillation of acid into the esophagus with a pH probe in place will allow determination of acid-clearing with swallowing. Normally, the esophagus will clear the hydrochloric acid within 10 swallows. Slower clearing suggests a motor abnormality. Barium cine esophagograms also may define motor abnormalities of the esophagus, particularly if barium spiked with 0.1 N hydrochloric acid is used.

### Management

Ingestion of fat should be limited because this stimulates the release from the small intestine of cholecystokinin, a hormone which relaxes the lower esophageal sphincter. Chocolate, which contains xanthines; carminatives (peppermint) and alcohol also are known to decrease lower esophageal sphincter pressure, and should be avoided. Coffee has been demonstrated to produce pyrosis not so much by stimulating acid secretion by the stomach, but, rather, by lowering LES pressure.

Smoking also is contraindicated in patients with reflux because of its effect on the lower esophageal sphincter. Citrus drinks do not affect the sphincter, but tend to irritate the already-damaged esophageal mucosa and produce symptoms. Salicylates are directly toxic to the esophageal mucosa and should be avoided. Anticholinergic agents should be avoided because they decrease pressure in the lower esophageal sphincter. They also slow gastric emptying, thereby allowing a greater reservoir of hydrochloric acid to be present in the stomach to reflux into the esophagus.

Obesity tends to increase reflux symptoms, and sometimes a decrease in weight will lead to relief of complaints.

Reduction of acid in the stomach is important. Cimetidine has been shown to be helpful for this reason. Liquid antacids also are effective, but must be given frequently (30 to 60 ml. at each meal, two hours after each meal, and at bedtime). This large dose requires that their side effects of constipation and diarrhea be controlled carefully by giving antacids with more or less milk of magnesia as required. Alginic acid-antacid combinations have been felt to be more effective than antacids alone because of the formation of a barrier of foam between the gastric contents and the esophagus. Actually, the commercially available compounds have a very low capacity to neutralize gastric acid, but seem to be quite effective clinically.

### Drug Results

Bethanechol has been demonstrated to increase tone in the lower esophageal sphincter, thus decreasing esophageal reflux. It has the disadvantage of stimulating acid secretion and biliary tract flow. Metoclopramide, a drug not yet available on the American market for this use, may have the advantage of increasing lower eosphageal sphincter pressure without causing increased gastric acid, pancreatic or biliary tract secretion.

Avoidance of tight abdominal binders such as corsets decreases reflux. Nocturnal reflux may be decreased by elevating the head of the bed on six-inch blocks or using a large bolster extending from buttocks to the top of the head.

In patients with esophageal stricture, esophageal dilatation is important. Following esophageal dilatation, however, it is essential to carry out a very extensive medical program to prevent recurrence of the stricture or to consider a surgical approach.

### Surgical Treatment

Surgical treatment is indicated in those patients with intractable reflux esophagitis and with symptoms which recur despite a previously adequate medical program. I feel that patients with bleeding, stricture, perforated esophageal ulcer and esophageal ulcer not responding to medical therapy should go to surgery.

The currently-favored anti-reflux operation is one that produces a "wrap-around" of gastric mucosa about the distal esophagus. This originally was described by Nissen, and his operation probably is still the most effective anti-reflux procedure.

The major complication of this particular procedure has been the "air bloat" syndrome, i.e., the inability to belch, following the operation. This can be prevented by putting a large mercury bougie into the stomach and esophagus at the time that the wrap-around is performed so that it is not made too tight.

Of the various anti-reflux operations available, three have received wide use in the United States. These include the Nissen, the Hill and the Belsy. Several recent studies have shown that the Nissen procedure is easier technically. It is performed through the abdomen, allowing the surgeon to look for associated disease, such as peptic ulcer. There also seems to be a much lower recurrence rate with this operation, and for these reasons I prefer it.

### Approach to the Patient

How, then, is the family physician, who probably doesn't have available the complicated equipment I have described, to manage his patient who presents with symptoms suggesting esophageal reflux? First, I would advise a two-week trial of treatment if the patient has symptoms only of pyrosis. This should consist of elevation of the head of the bed on six-inch blocks or use of a bolster extending from buttocks to head (better tolerated than blocks) to prevent nocturnal reflux. The patient should eat frequent small feedings of a high-protein, low-fat diet and, if overweight, should be instructed in a weight-reduction program.

No fluid or food should be taken after the evening meal. Alginate-antacids tablets or antacids tablets or antacids should be taken at meals, three hours after meals, and at bedtime to neutralize acid. Alcohol, tobacco, caffeine, carminatives, salicylates and all drugs with an anticholinergic action should be stopped. Tight abdominal binders should be discarded.

If the patient has symptoms of dysphagia, or if there is no response to the above program in the patient with pyrosis alone, an attempt to confirm the diagnosis should be made immediately. A Bernstein acid perfusion test to confirm that the pain is esophageal should be performed. A barium esophagogram should be obtained. If these tests do not define the problem completely, esophagoscopy with mucosal biopsy and pH probe should be done. It may be necessary to refer the patient for these studies. When the diagnosis is confirmed the patient can be given Cimetidine 300 mg. at each meal and at bedtime, and/or Bethanechol 25 mg. before each meal and at bedtime.

Finally, if there is no response to the above, anti-reflux surgery should be considered. Anti-reflux surgery should be considered immediately if there is: pulmonary aspiration; an obstruction which can't be handled easily with dilatation plus an intensive medical program or in which there is a question of a malignancy; perforation of an esophageal ulcer or failure of an esophageal ulcer to heal with an intensive medical program; or esophageal bleeding.

### References


1. Nebel OT, Castell D: Lower esophageal sphincter pressure changes after food ingestion. *Gastroenterol* 63:778-783, 1972.

2. Hendrix TR, Yardley JH: Consequences of gastroesophageal reflux. *Clin Gastroenterol* 5:155-174, 1976.

3. Castell D: The lower esophageal sphincter: Physiologic and clinical aspects. *Ann Intern Med* 83:390-401, 1975.

4. Behar J, Biancaine P, Sheahan DC: Evaluation of esophageal tests in the diagnosis of reflux esophagitis. *Gastroenterol* 71:9-15, 1975.

5. De Meester TR: Patterns of gastroesophageal reflux in health and disease. *Ann Surg* 184:459-470, 1976.

6. Farrell RL, Roling GT, Castell DO: Cholinergic therapy of chronic heartburn: A controlled trial. *Ann Intern Med* 80:573-576, 1974.

7. Fisher RS, Cohen S: Gastroesophageal reflux. *Med Clin N Am* 63:3-20, 1978.

8. Fisher RS: Gastroesophageal (GE) scintiscanning to detect and quantitate GE reflux. *Gastroenterol* 70:301-308, 1976.

9. Stancin C, Bennett JR: Alginate/antacid in reduction of gastroesophageal reflux. *Lancet* 1:109-111, 1974.

*A Continuing Medical Education Event!*

# The 14th Mid-Winter Clinical Conference

Holiday Inn Charleston House

600 Kanawha Boulevard, East, Charleston, W. Va.

**January 23-25, 1981**

**WEST VIRGINIA STATE MEDICAL ASSOCIATION**
**WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE**
**MARSHALL UNIVERSITY SCHOOL OF MEDICINE**

## WATCH THE JOURNAL FOR PROGRAM DETAILS

THE PROGRAM CO-CHAIRMEN again are Ralph H. Nestmann, M. D., and Joseph T. Skaggs, M. D., both of Charleston. Also on the Program Committee are William O. McMillan, Jr., M. D., of Charleston, Maurice A. Mufson, M. D., Huntington; Robert L. Smith, M. D., Morgantown, and C. Carl Tully, M. D., South Charleston.

THE REGISTRATION FEE of $40 for the entire conference will be charged all registrants except nurses, medical students, interns and residents. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

ACCREDITATION: Attendance will be acceptable for 13 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association; and the program also is acceptable for 13 Prescribed hours by the American Academy of Family Physicians.

OVERNIGHT ACCOMMODATIONS: Physicians should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters hotel setting aside rooms for registrants.

FOR ADVANCE REGISTRATION, please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. VA. 25324.

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Please register me for the 14th Mid-Winter Clinical Conference in Charleston, W. Va., January 23-25, 1981. My $40 registration fee is (is not) enclosed.

| | |
|---|---|
| *Name (please print)* | *Specialty* |
| *Address* | *City* |

*A message from . . .*

*The President*

## COST CONTAINMENT

THIS article will be confined to hospital costs, although the subject is too large to discuss thoroughly in one President's Page.

Hospital costs have soared beyond the rise in inflation for some time. The *profit margin* in hospital management has become so great that large companies—HCA, Humana, National Med Enterprises—are now running hospitals. The return on equity is a healthy 25 per cent.

What changes have increased hospital costs?

(a) Interns, residents, nurses and other hospital workers are now paid a living wage. This is only right. The $25 per month plus room and board of my intern period fortunately is history.

(b) Many new tests and procedures are present today. A medical student frequently did the basic lab tests 40 years ago. Today, a skilled technologist performs them on some pretty fancy and expensive equipment. These improvements are good.

(c) Today's hospital is a maze of private and semiprivate rooms, huge record rooms, and large offices for everyone from administrator to chief maintenance supervisor. How many of these costs could be reduced or eliminated? *Private rooms*—in one man's view (mine)—are not only undesirable but detrimental to the care of the patient. Such rooms leave them isolated, unobserved and require much more individual, bedside nursing care. Most hospitals need marked reduction in private rooms. The good old four-bed ward concept has great advantage of cost reduction, observation by nurse and other patients if things go wrong (i.e., a fall out of bed), and social exchange to divert mind from pain and suffering.

(d) Then there are *gourmet meals* requiring skilled cooks and dieticians in excess of numbers needed for good basic nutrition. As a former cook, I find it disheartening to see 50 per cent of gourmet meals returned only partially eaten.

(e) *Color TV sets and Princess phones* are luxury hotel services. They do not belong in hospital rooms. They prolong the stay of those who are not seriously ill and interfere with the recovery of those who are truly sick. Phone calls from friends to awaken a sick patient—bah! A patient recovery room with one TV set and phone use should suffice.

We physicians can help reduce these costs by: (a) Hospitalizing only when necessary; (b) Ordering only those procedures really needed; and (c) Acting in a responsible manner on the boards to reduce some of the unnecessary extra services.

Elimination of the reams of unnecessary paperwork is an area being addressed by your State Medical Association and the AMA, but needs much more help.

If we don't curtail some of these costs, the insurance industry will not be able to provide them within the capability of the individual, industry or the government. This will result in government takeover that will limit them beyond the point of desirability.

L. Walter Fix, M.D.

L. Walter Fix, M. D., *President*

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

It's bite-the-bullet time—in fact, it's past that time—for West Virginia physicians and their malpractice insurance program. Dr. L. Walker Fix addressed the situation in general terms in his President's Page in the October issue of *The Journal*. Now, the Medical Association leadership is moving to put some solid flesh on the bones of a risk management program in cooperation with Aetna Life & Casualty.

**RISK MANAGEMENT AND THE DOCTOR**

No one questions for a moment that considerable work has been done, through quality assurance and other activity by hospital medical staffs and in other settings, toward loss control and education designed to weed out causes of perhaps a major part of the current insurance dilemma.

Physicians in various parts of the state have organized and participated in medical education and other seminars. Topics such as the vital need for complete medical records, patient rapport and numerous others have been developed with Aetna, with an increasing emphasis on West Virginia experience, and made available in substantial volume for continuing medical education and other purposes.

What has been done, however, including a quarterly informational bulletin prepared by Aetna and the Medical Association, simply has not been enough. In stark reality, the medical profession must have much deeper involvement with problems that give rise to many malpractice claims. Ballooning insurance premiums are of concern to everyone, including the general public which will have to foot the bill in large and uncomfortable measure. But premiums fall to a major degree in the category of symptoms of problems, and not causes.

In simple terms, new physician attention needs to be directed to procedures under which physicians are licensed to practice in the state. Some hard-nosed questions must be asked about hospital privileges. Are they granted in some instances in too loose a fashion, and do some physicians have privileges to practice beyond their capabilities? And are various audit and other hospital committees—recognizing, again, the effective work of many—still falling short of what really needs to be done to assure the highest possible quality of care?

Under the best of circumstances, there will be some poor results in medical care. The injured should be compensated. Poor results do not necessarily imply or stem from malpractice. But to the degree it is possible, through reasonable and fair monitoring and guidance, and other avenues, these poor results must be reduced.

An insurability committee within the top framework of the Medical Association will be addressing a variety of matters related to insurance coverage and physician performance. It will develop its program with maximum fairness and care; and its efforts certainly will be coordinated with such other components as the new Committee on Physician Services, medical staffs and others throughout the state—and the West Virginia Board of Medicine (formerly the Medical Licensing Board).

The job ahead will not be easy—but it is absolutely essential regardless of what company is providing insurance for doctors, or whether physicians in West Virginia eventually set up their own program. Risk management simply is the biggest game in town in the insurance picture. And for a captive company, which must assume the total risk for providing coverage, its importance is magnified.

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**THE PHYSICIAN AND THE PUBLIC**

Elsewhere in this issue of *The Journal* is an outline of further changes in policies and procedures instituted by the West Virginia Workmen's Compensation Fund.

The State Division of Vocational Rehabilitation is giving additional, detailed study to several of its operational policies, with results of a survey of physicians playing a major role.

A committee including State Medical Association, West Virginia Hospital Association and other representatives, including several from state agencies and institutions, has begun work with St. Joseph's Hospital in Parkersburg on community-level planning toward new medical rehabilitation services for state residents.

These activities, and a number of others, are adding new dimensions to grass roots as well as broad involvement in what the Medical Association Constitution envisions as promotion of the public health.

Collectively, these efforts represent a substantial contribution with potentially significant impact on the availability and quality of medical care. In several instances, they promise at least to reduce the bugaboo of paper and other delays that impede service to injured workers, to those needing rehabilitation services, and others.

This new range of activity also reflects increased input and assistance from individual physicians throughout the state, through such means as making themselves available in significantly larger numbers in response to a Workmen's Compensation Fund call for additional examiners.

From the standpoint of a single program, on a given day, this stepped-up activity will not often create much in the way of headlines in today's highly complex and confused world. But taken as a whole, what's happening is most important, and will become more so.

The effort toward filling the recognized gap in medical rehabilitation services, for example, has unlimited potential. The current work in basic planning was born in 1978 in Medical Association committees, and formally endorsed by the Council and House of Delegates.

Two legislative appropriations of $50,000 each for fiscal 1979-80 and 1980-81, set up as line items in a State Health Department account, have made possible preliminary activity at so-called tertiary centers in Morgantown, Charleston and Huntington, as well as the community-level project in Parkersburg. Another small grant from the 1979-80 appropriation was earmarked to assist in additional medical rehabilitation planning at a Wheeling hospital.

The bottom line, to use a modern-day label, in any effort in the field of medical and health care must be the public health and welfare. West Virginia's physician population is becoming a significantly stronger component of such activity. And as programs become stronger and more effective, from the cost as well as other standpoints, physicians will deserve a lion's share of credit and recognition.

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**OVERALL IMPACT?**

Will the recent U. S. Supreme Court decision on Medicaid abortion funding have an impact on federal policies toward all beneficiaries? And if so, how important might that impact be?

The Court said, in effect, that Congress has a right to impose restrictions on benefits that might be available to the general public. Justice and opinion-watchers have been rolling the language about without any apparent early agreement.

By coincidence, the Court's ruling came as the U. S. Health and Human Services Department (formerly HEW before Education became free-standing) was studying what constitutes "reasonable and necessary" medical services that Medicare and Medicaid should finance. Another study has involved heart transplantation and how and whether Medicare patients should be reimbursed for the procedure.

In the abortion case, the Justices upheld, 5-4, Congress' restrictions on Medicaid abortions, limiting federal payment to abortions needed to save the lives of mothers or in cases of rape or incest.

The so-called Hyde Amendment, named for Representative Henry Hyde, Illinois Republican, has plunged Congress into annual debate for four years, with the amendment forces winning each time. As a result of the Hyde Amendment, Medicaid-funded abortions have dropped from 300,000 before 1976 to less than 2,000 in 1979.

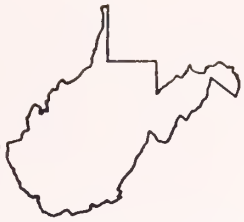
Pro-abortion and anti-abortion forces have collided bitterly on the issue and hammered at Congress unceasingly. More congressional mail has been generated on abortion than on any other subject.

Supreme Court Justice Potter Stewart, writing for the majority, said that "although Congress has opted to subsidize medically-necessary abortions, the fact remains that the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically-necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all." He added:

"We are thus not persuaded that the Hyde Amendment impinges on the constitutionally-protected freedom of choice recognized in (a prior Court ruling)."

In a second 5-4 vote, the Court said states are not obligated to pay for medically-necessary abortions for which federal reimbursement is not available.

# GENERAL NEWS



## Role Of IPAs, HMOs Subject Of Conference Panel

Five additional members of a panel on the role of Individual Practice Associations (IPAs) and Health Maintenance Organizations (HMOs) to be held during the 11th Mid-Winter Clinical Conference have been announced by the Program Committee.

Charles G. Brown, J. D.

William C. Graham, M. D.

The panel will constitute the concluding Sunday morning, January 25, session of the annual continuing medical education event, which will get under way Friday afternoon, January 23, in Charleston at the Holiday Inn Charleston House.

Sponsors are the State Medical Association and the Marshall University and West Virginia University Schools of Medicine.

The panelists will be Jacob Spies of Boston, Director of Health Systems, Boston University Health Policy Institute; James G. Stumpfel of Wheeling, Executive Director, The Health Plan of the Upper Ohio Valley, Inc. (HealthPlan), an IPA; Mrs. Carol Miller of Beckley, Executive Director, Healthwise, also an IPA; John F. Otto, M. D., Huntington, Clinical Assistant Professor of Medicine, MU School of Medicine, who is coordinating the establishment of an HMO in that city, and Charles G. Brown, J. D., of Charleston, Deputy Attorney General and Director of the Antitrust Division, West Virginia Attorney General's Office.

The sixth member of the panel, as announced previously, will be Frederick M. Cooley, M. D., of Charleston, Medical Advisor of the developing Charleston HMO.

State Health Director George E. Pickett, M. D., will be moderator for the panel.

The conference program meets the criteria for 13 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association, and also is acceptable for 13 Prescribed hours by the American Academy of Family Physicians.

### Other Speakers Named

A number of other conference speakers also were announced by the Program Committee.

Carl J. Malanga, Ph.D., of Morgantown, Professor of Biochemistry, Department of Pharmacy, WVU, will talk on "Drug Interactions" during the Saturday morning session.

Two papers will be given Saturday morning under the general topic of "Antibiotic Update." Patrick Robinson, M. D., Department of Internal Medicine, WVU Charleston Division, will discuss "Aminoglycosides," and William C. Graham, M. D., MU Assistant Professor of Medicine, Section of Infectious Diseases, "Cephalosporins."

L. Blair Thrush, M. D., of Morgantown, WVU Assistant Professor and Chief, Section on Allergy and Clinical Immunology, also will talk Saturday morning on "Drug Allergy."

Speaking during the Saturday afternoon session on "Current Controversies In Medicine" will be John C. Linton, Ph.D., Associate Professor and Chief Psychologist, Department of Behavioral Medicine and Psychiatry, WVU Charleston Division, who will take the behavioral modification approach in the "Treatment of Obesity."

Mohammed M. Boustany, M. D., Clinical Assistant Professor of Surgery, WVU Charleston Division, as announced previously, will discuss surgical treatment of obesity.

In a discussion of "TIA: Is Surgery Indicated?," Arthur L. Poffenbarger, M. D., of Charleston, WVU Clinical Professor of Neurology, will take the "con" position, while G. Robert Nurgent, M. D., of Morgantown, WVU Professor of Surgery and Chairman, Department of Neurosurgery, also as announced previously, will take the "pro" position.

The conference will open at 2 P. M. Friday with two speakers on fiberoptics and a paper on "Overview of Microsurgery." Under the fiberoptics discussion, there will be a paper on "Endoscopic Retrograde Cholangio Pancreatography (ERCP)" and, as announced previously, a presentation by James W. Manier, M. D., of Morgantown on "Indications for Colonoscopy."

Doctor Manier is WVU Professor of Medicine and Chief, Section of Gastroenterology.

#### Physicians' Session

A physicians' session at 8 P. M. Friday will be conducted by the West Virginia Medical Institute, Inc., concurrently with a public session on "What's New in Allergy."

Doctor Graham, a Diplomate of the American Board of Internal Medicine, has held his position at MU since July of this year. He was graduated from Brown University in Providence, Rhode Island, and received his M. D. degree in 1975 from that institution.

Doctor Graham served his internship and residency at Rhode Island Hospital in Providence, and completed a fellowship in infectious disease at Brown University Affiliated Hospitals.

Deputy Attorney General Brown is a graduate of Denison University, Granville, Ohio, and Yale University Law School. He was staff attorney for the Federal Trade Commission from 1975 to 1978, and earlier was employed by Ralph Nader on consumer and environmental projects, and by Charles Evers as a civil rights worker.

Attorney General Chauncey H. Browning created the West Virginia Antitrust Division on June 1, 1978, naming Brown as its first Director.

A registration fee of $40 will be charged all registrants except nurses, medical students, interns and residents. For advance registration, make checks payable to West Virginia State Medical Association, and mail to the Association at P. O. Box 1031, Charleston 25324.

#### Program Committee

Serving on the Program Committee are Drs. Ralph H. Nestmann and Joseph T. Skaggs, both of Charleston, Co-Chairmen; and Drs. William O. McMillan, Jr., Charleston; Maurice A. Mufson, Huntington; Robert L. Smith, Morgantown, and C. Carl Tully, South Charleston.

The Committee also is receiving assistance from WVU Charleston Division staff members J. Zeb. Wright, Ph. D., Coordinator of Continuing Education, Department of Community Medicine, and Sharon A. Hall, Conference Coordinator.

The remaining speakers, and other conference details, will appear in the December and January issues of *The Journal.*

## Registrations For 'Frostbite Frolic' Run Invited

The third annual "Frostbite Frolic" 5,000- and 10,000-meter runs will be held in Charleston Saturday, January 24, in conjunction with the 14th Mid-Winter Clinical Conference.

The runs will begin at 8:30 A. M. at the WVU Medical Education Building (31st Street and Virginia Avenue).

There will be age division awards and special awards for medical students and house staff physicians as well as attending physicians.

For registration forms please contact Dr. Alfred K. Pfister, Kanawha Valley Road Runners Club, 794 Echo Road, South Charleston 25303.

## AMA Delegates To Meet In San Francisco

The 1980 Interim Meeting of the House of Delegates of the American Medical Association will be held December 7-10 in San Francisco (San Francisco Hilton Hotel).

West Virginia's Delegates to the AMA House are Drs. Frank J. Holroyd of Princeton and Richard E. Flood of Weirton, with Drs. Jack Leckie of Huntington and Harry S. Weeks, Jr., of Wheeling as Alternate Delegates.

The official call for the December meeting is published in the October 3 *Journal of the American Medical Association.*

The 279 delegates will represent state medical associations, national medical specialty societies, resident physicians, medical students, medical schools, medical corps of the Army, Navy and Air Force, Public Health Service and Veterans Administration.

The delegates will consider a variety of proposals to govern the affairs of the AMA in 1981 and beyond.

Robert B. Hunter, M. D., of Sedro Woolley, Washington, is AMA President. The Speaker of the House is William Y. Rial, M. D., of Swarthmore, Pennsylvania. The Secretary-Treasurer of the AMA is William S. Hotchkiss, M. D., of Norfolk, Virginia.

## Continuing Education Activities

Here are the continuing medical education activities listed primarily by the West Virginia University School of Medicine for part of 1980 and 1981, as compiled by Dr. Robert L. Smith, Assistant Dean for Continuing Education, and J. Zeb. Wright, Ph. D., Coordinator, Continuing Education, Department of Community Medicine, Charleston Division. The schedule is presented as a convenience for physicians in planning their continuing education program. (Other national, state and district medical meetings are listed in the *Medical Meetings* Department of The Journal).

The program is tentative and subject to change. It should be noted that weekly conferences also are held on the Morgantown, Charleston and Wheeling campuses. Further information about these may be obtained from: Division of Continuing Education, WVU Medical Center, 3110 MacCorkle Avenue, S. E., Charleston 25304; Office of Continuing Medical Education, WVU Medical Center, Morgantown 26506; or, Office of Continuing Medical Education, Wheeling Division, WVU School of Medicine, Ohio Valley Medical Center, 2000 Eoff Street, Wheeling 26003.

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|---|---|---|
| Nov. 7 | Charleston | The Arthur B. Hodges Center Symposium on Diabetes and Aging |
| Nov. 21-22 | Morgantown | 1st Annual Sports Medicine Symposium |
| Dec. 6 | Charleston | Arthritis Synposium |
| | **1981** | |
| Jan. 28-31 | Showshoe Ski Resort | 2nd Mid-Winter Cardiovascular Symposium |

### Regularly Scheduled Continuing Education Outreach Programs from WVU Medical Center/ Charleston Division

*Buckhannon*, Upshur-Buckhannon Middle School, 3rd Thursday, 7-9 P. M. — November 20, "Trauma to the Head," A. L. Poffenbarger, M. D.

*Cabin Creek*, Cabin Creek Medical Center, Dawes, 2nd Wednesday, 8-10 A. M. — November 12, "Fertility and Sterility: Management and Treatment," John T. Chambers, M. D.

*Oak Hill*, White Oak Country Club, 4th Tuesday, 7-9 P. M. — November 25, "Congestive Heart Failure," David Namay, M. D.

*Welch*, Stevens Clinic Hospital, 3rd Wednesday, 11 A. M.-1 P. M. — November 19, "Interactive Relationship of Commonly Prescribed Drugs," Terry Prettyman, R. Ph.

*Whitesville*, Raleigh-Boone Medical Center, 4th Wednesday, 11 A. M.-1 P. M. — November 19,* "Hypertension: Diagnosis and Treatment," T. Ray Perrine, M. D.

*Williamson*, Appalachian Power Company Auditorium, 1st Thursday, 6-8 P. M.—November 6, "Burns," Augusto Portillo, M. D.

*Scheduled on third Wednesday because of Thanksgiving.

### Uniform Health Care Claim Form Gets Approval

Effective January 1, 1981, West Virginia physicians may submit claims for reimbursement to all third-party payors on the American Medical Association's Health Insurance Claim Form.

The joint Legislative Rule-Making Review Committee of the West Virginia Legislature, on October 6, approved regulations mandating acceptance of Uniform Health Care Claim Forms.

The State Medical Association has been seeking such a regulation for more than seven years.

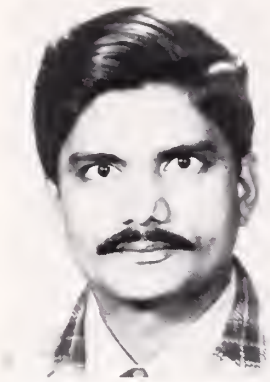
The new form, according to the State Insurance Commission order authorizing it, will not apply to claims involving disability income coverage, credit disability income coverage, or coverage under a vision care program "since the data required for determination of coverage and benefits differ substantially from that included in the included claim forms."

Included among those third parties which will be expected to come under the new format are the West Virginia Department of Welfare and Workmen's Compensation Fund.

## Rehabilitation Specialist Named At Institute Center

The appointment of Dr. Prasadarao B. Mukkamala as head of the Medical Services Program at the West Virginia Rehabilitation Center at Institute has been announced by State Rehabilitation Director Earl W. Wolfe.

Doctor Mukkamala will direct the Center's medical program for severely disabled clients of the Division of Vocational Rehabilitation, and will coordinate a staff of physical and occupational therapists, medical personnel at the Center's treatment unit, and other professional workers.



Prasadarao Mukkamala, M.D.

Wolfe hailed Doctor Mukkamala's appointment "as a basic step in stengthening the Center's program of medical and related services to West Virginians with severe disabilities, particularly the spinal cord-injured."

Before joining the staff of the Center, Doctor Mukkamala served as Assistant Director of Rehabilitation Medicine at New York Medical College. He did his residency in rehabilitation medicine at City Hospital Center in Philadelphia, an affiliate of Mount Sinai Hospital in New York.

He completed his undergraduate work at VSR University in Tenali, India, in 1961, and graduated from Rangaraya Medical School in Gutu, India. He also completed two years of postgraduate work in general surgery.

The Center's approach is consistent with rehabilitation medicine, Doctor Mukkamala explained, in that the "total client" is addressed in the way his or her disability affects the physical, psychological, emotional and social aspects of personality, and thus the client's potential for returning to gainful employment.

Doctor Mukkamala lives in the Charleston area with his wife Jayasree and their two daughters.

## New Committee On Planning Offers Initial Goals

Coming months will find the Medical Association's newly established standing Committee on Long Range Planning giving further attention to goals and objectives first proposed while it was operating in an ad hoc status.

The Association's Council accepted at a special meeting in August the group's first report which offered a set of recommendations and endorsements. These were fashioned at the Committee's initial meeting in mid-summer.

Here is the foundation upon which the Committee has proposed the Association approach future program and other development, in line with a House of Delegates charge that it monitor

**Three Past Presidents of the State Medical Association (left photo) enjoy a discussion at a meeting of the House of Delegates during the Association's Annual Meeting in August at the Greenbrier in White Sulphur Springs. From left, are Drs. Joseph A. Smith, Dunbar; William E. Gilmore, Parkersburg, and Jack Leckie, Huntington. In the right photo, also during a House session, physicians compare notes on the proceedings. They are, from left, Drs. Carl J. Roncaglione, Charleston, a former member of the Association's Council; John B. Markey, also of Charleston, Association President Elect, and Harry Shannon, Parkersburg, who was elected Vice President of the Association during the Annual Meeting.**

on an ongoing basis services and other activities of the Association; and make appropriate recommendations to the Council for review and action:

—A recommendation that the Association's Committee on Legislation schedule an October meeting each year to develop a positive program, for Council review in November, for the Legislature convening early in the following January. The recommendation would further direct the Committee on Legislation to obtain input from other Committees, local medical societies and other appropriate sources, including individual members with specific suggestions for legislation, prior to its October meeting. A meeting of the Committee on Legislation is currently scheduled for November 15, with Council to meet the following day. Both meetings will be in Charleston.

—A call for development of new, innovative methods of communication by the leadership and headquarters staff with the membership as one step toward solidifying Association organization. These would include polls of the membership on important questions and issues; and questionnaires designed to obtain grass-roots input for Association direction.

—A recommendation calling for further and continuous steps to establish closer liaison with other health care providers, including hospitals, dentists, nurses, pharmacists, etc.

—A recommendation that the Committee on Long Range Planning provide for, in conjunction with the headquarters staff, a regular report (perhaps each six months) to the membership detailing Association activities, and soliciting feedback from members. Specific steps would be taken to ensure that such reports would complement, and in no way bypass, similar work by Councilors and component society secretaries.

—A recommendation calling for development of a Placement Bureau to assist physicians interested in locating in West Virginia; and to provide broadened assistance to community groups seeking to meet needs for physicians' services.

—Endorsement of proposed Constitution and By-Laws amendments, first offered to the House of Delegates in August, 1980, to open membership in the Association to osteopathic physicians licensed to practice in West Virginia; and to osteopathic school students. These proposed amendments were introduced this year, and will be up for final action by the House on August 20, 1981.

—Endorsement of steps necessary to assure adequate staffing and housing for the Association headquarters.

—Endorsement of a review and re-evaluation of the Association's Constitution and By-Laws, with particular attention to means of providing a

**Dr. Stephen D. Ward, right, Wheeling psychiatrist and then President of the State Medical Association, receives a packet of volcanic ash from Mt. St. Helens in Washington from Dr. Rogers J. Smith of Portland, Oregon, during the Association's Annual Meeting in August at the Greenbrier in White Sulphur Springs. Doctor Smith, also a psychiatrist, was a speaker for the second general session of the convention.**

# *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*Basic Histology, 3rd Edition*, by Luis C. Junqueira, M. D.; and Jose Carneiro, M. D. 504 pages. Price $15.50. Lange Medical Publications, Los Altos, California 94022. 1980.

*Review of Medical Physiology, 9th Edition*, by William F. Ganong, M. D. 618 pages. Price $14. Lange Medical Publications, Los Altos, California 94022. 1979.

*Review of Medical Pharmacology, 7th Edition*, by Frederick H. Meyers, M. D.; Ernest Jawetz, M. D., Ph.D.; and Alan Goldfien, M. D. 747 pages. Price $17.50. Lange Medical Publications, Los Altos, California 94022. 1980.

more effective committee structure attuned to needs of the times.

—Endorsement, in relation to the material immediately above, of a redefinition of responsibilities of the Association Committee on Public Service. Such redefinition specifically would include development of an Association Speakers' Bureau; and responsibility for shaping clear explanations of factors reflected in costs of medical care, and coordinated cost containment programs.

—Endorsement of continued efforts to develop, and encourage attendance at, continuing medical education programs of voluntary nature.

—Continued endorsement of an Association-sponsored professional liability insurance program designed to provide maximum benefits to the membership.

The Committee on Long Range Planning is chaired by Dr. Richard E. Flood of Weirton. Other members are Drs. John B. Markey of Charleston, the Association's President Elect; Harry Shannon of Parkersburg, Vice President; Louis C. Palmer, Bridgeport, and John A. Mathias, Buckhannon.

## Honorary, Retired Members Approved By Council

The Medical Association's Council, during an August 10 meeting, elected the following physicians to honorary membership after appropriate action by their respective component societies:

Drs. Samuel I. Nichols, Berkeley Springs, Eastern Panhandle Medical Society; H. Charles Ballou, White Sulphur Springs, and Lee B. Todd, Quinwood, both Greenbrier Valley; George W. Rose, Clarksburg, Harrison; John L. Van Meter, Charles Town, Jefferson; I. M. Kruger, Virginia Beach, Virginia, Logan; Robert W. Coplin, Elizabeth, Parkersburg Academy; Preston C. Davis, Beckley, Raleigh, and L. H. Nefflen, Elkins, Tygart's Valley.

Elected to retired membership was Dr. Mary Jordan, Fairmont, a Marion County Medical Society member.

Those accorded honorary membership, along with others voted a similar change in status since August, 1979, were officially recognized by the House of Delegates during the Association's Annual Meeting in White Sulphur Springs August 20.

## AMA Official Says Report Lacks Flexibility

The methodology of a government-sponsored report which recently was released has been questioned by James H. Sammons, M. D., Executive Vice President of the American Medical Association. The report, which recommends new goals and limits for the American medical education system, was prepared by the Graduate Medical Education National Advisory Committee (GMENAC).

"Because of the methodology used, it is necessary to view the report and the recommendations of the GMENAC Committee with caution before they are applied to the American health care system," said Doctor Sammons. "There is a necessity for evaluating and determining the nation's health needs," Doctor Sammons continued, "but our concern is that this report has the potential to set the American system on a rigidly defined course with little flexibility of goals or the means of attaining them. We must keep in mind that while the GMENAC findings may provide an interesting assessment of manpower projections and supply today, history has shown that long-term medical manpower projections are extremely difficult to make, given changing economic trends, technological innovations, a mobile population and a rising demand for services."

### Questions Doctor-Surplus Forecast

At the heart of the report is GMENAC's assessment that there will be a surplus of nearly 70,000 physicians in the United States by 1990. This conclusion is derived from a marrying of professional opinion with a sophisticated mathematical model. The results of this process can be no better than the assumptions of the professionals, the AMA noted. And the assumptions on which GMENAC's projections are based are controversial and subject to numerous interpretations, according to Doctor Sammons.

The Committee is composed of 21 members, of whom 13 are physicians. Chartered by the Secretary of Health, Education and Welfare in April, 1976, GMENAC was created for the purpose of making recommendations to the Secretary of Health and Human Services concerning ways "to achieve an appropriate number of physicians in each specialty, to assure adequate financing mechanisms for graduate medical education, and to achieve a proper utilization of other categories of complementary manpower."

The report contains 100 recommendations.

## Diabetes, Aging Conference Planned In Charleston

Visiting physicians from Indianapolis and Cornell University Medical Center will be among the faculty for a symposium on diabetes and aging on November 7 in Charleston.

The one-half-day Arthur B. Hodges Center Symposium on Diabetes and Aging will begin with registration at 8:30 A. M. at the West Virginia University Medical Center Education Building, concluding at noon.

Sponsors are WVU Charleston Division and the Charleston Area Medical Center.

The speakers and their topics will be "Introduction to the Biology of Aging"—Marc Weksler, M. D., Professor of Medicine, Cornell University Medical Center; "Diagnosis of Diabetes in the Elderly"—Stephen R. Grubb, Assistant Professor of Medicine, WVU Charleston Division; "Management of Diabetes in the Elderly" —William C. Duckworth, M. D., Professor of Medicine, Veterans Administration Medical Center, Indianapolis;

"Immunologic Basis of Diabetes"—Doctor Weksler; "Special Aspects of Treatment of the Elderly Diabetic"—Doctor Duckworth, and Panel Discussion (faculty).

The program meets the criteria for three and one-half credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

**Mrs. D. Sheffer Clark (center) of Huntington, then President of the Auxiliary to the State Medical Association, is shown with honor guests during the 56th Annual Meeting of the Auxiliary in August at the Greenbrier in White Sulphur Springs. They are Mrs. John F. Vaughan (left) of Vancouver, Washington, President of the American Medical Association Auxiliary, and Mrs. Raymond M. Yow of Salisbury, Maryland, President of the Southern Medical Association Auxiliary.**

For registration and other information, contact the Conference Coordinator at (304) 347-1242.

## Ventricular Arrhythmias Heart Group Meeting Subject

"Ventricular Arrhythmias: Diagnostic and Therapeutic Approach" will be the theme of the Second Mid-Winter Cardiovascular Symposium to be held January 28-31 at Snowshoe Ski Resort, Slaty Fork.

The American Heart Association is conducting the symposium, with the Charleston Division, West Virginia University Medical Center, and the Charleston Area Medical Center serving as co-sponsors.

Registration, which will be limited, is required by November 28, and all room reservations with the ski resort must be made by December 1.

The faculty will include Drs. Richard S. Crampton, Professor of Medicine, University of Virginia; Robert DiBianco, Assistant Professor of Medicine, Georgetown University; John J. Gallagher, Professor of Medicine and Director, Clinical Electrophysiology Laboratory, Duke University; Philip R. Reid, Assistant Professor of Medicine, Johns Hopkins University; Jeremy N. Ruskin, Director, Clinical Electrophysiology Laboratory, Massachusetts General Hospital, and Harvey Waxman, M. D., Assistant Professor of Medicine, University of Pennsylvania Hospital.

Papers will be presented under the individual session titles of "Electrophysiologic Evaluation Arrhythmias," "Treatment of Ventricular Arrhythmias," "Identification and Treatment of High-Risk Subgroups," "Ventricular Arrhythmias: Treatment of High-Risk Subgroups," and "Refractory Malignant Ventricular Arrhythmias."

The program is approved for 10 hours of credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

State physicians who will preside at the sessions will be Drs. William J. Echols, Huntington; Abnash C. Jain, Morgantown; Creel S. Cornwell, Jr., Clarksburg; and Drs. William H. Carter and Harold Selinger, both of Charleston.

The registration fee is $125.

For registration and other information, contact the West Virginia Heart Association office (304/346-5381); for Snowshoe reservations (304/799-6762).

## Trauma, Bacterial Infections Of 'Major Concern' Today

The Second Annual Rowland H. Burns, M. D., Memorial Critical Care Conference, scheduled Saturday, November 8, by the Marshall University School of Medicine, will focus on "Trauma and Sepsis in the ICU."

"The frequency with which we see trauma in our community hospitals and the serious threat to patient health that bacterial infections pose make these issues of major concern to physicians today," said Charles E. Turner, M. D., MU Clinical Associate Professor of Medicine, who is conference planning Chairman.

"Despite the lowering of the highway speed limit, the number of multiple trauma cases is on an upswing, especially those involving young people in car and motorcycle accidents," Doctor Turner continued.

"As physicians, we face a major challenge to integrate surgical and medical care for the management of trauma patients. Sepsis in intensive care patients and the skillful use of supportive measures—including antibiotics—are still grave concerns to current physicians," he added.

The conference will be held in MU's Memorial Student Center.

See the October issue of *The Journal* for speakers and topics. Registration and additional information may be obtained by calling Charles W. Jones, Ph. D., MU School of Medicine CME Director, at (304) 696-4822.

## State Specialty Groups Elect Officers

The West Virginia Association of Pathologists and the West Virginia State Society of Anesthesiologists have elected new officers for 1980-81.

The pathologists elected Dr. Cordell A. DeLaPena of Clarksburg as its President. Other new officers are Drs. Nathaniel F. Rodman, Jr., Morgantown, President Elect; Bobby Caldwell, Charleston, Secretary-Treasurer, and Michael M. Stump V, Elkins, member of the Board.

Dr. John F. I. Zeedick of Charleston was elected President by the anesthesiologists. Also named were Drs. Richard B. Knapp, Morgantown, Secretary-Treasurer; Doctor Zeedick, Delegate; Eduardo A. Rivas-Pardo, Huntington, Alternate Delegate, and Jeanne A. Rodman, Morgantown, Alternate Director.

# *Medical Meetings*

Nov. 2-7—Am. Academy of Ophthalmol., Chicago.

Nov. 8—Rowland H. Burns, M. D., Memorial Critical Care Conference (MU School of Med.), Huntington.

Nov. 9-13—International Congress for Interferon Research, Washington, D. C.

Nov. 10-11—Reconstructive Surgery of the Hip (Johns Hopkins), Baltimore.

Nov. 12-15—Am. Heart Assn., Miami.

Nov. 13-15—Southern Thoracic Surgical Assn., White Sulphur Springs.

Nov. 13-15—A National Forum on Comprehensive Cancer Rehabilitation and its Vocational Implications (Va. Dept. of Rehabilitative Services, MCV), Williamsburg, Va.

Nov. 14-16—AMA Regional Meeting, New York City.

Nov. 16-19—Southern Med. Assn., San Antonio, Texas.

Dec. 6-11—Am. Academy of Dermatology, New York City.

**1981**

Jan. 14-16—Am. Diabetes Assn., Phoenix, Ariz.

**Jan. 23-25—14th Mid-Winter Clinical Conference, Charleston.**

Feb. 1-4—Am. Hospital Assn., Washington, D. C.

Feb. 22-25—Southeastern Surgical Congress, New Orleans.

March 8-12—Society of Head & Neck Surgeons; and Am. Society for Head & Neck Surgery, Phoenix, Ariz.

March 23-25—Am. Society of Abdominal Surgeons, Tampa, Fla.

March 23-27—Am. Roentgen Ray Society, San Francisco.

April 6-9—Am. College of Physicians, Kansas City, Mo.

April 8-11—Tenn. Med. Assn., Knoxville.

April 10-12—WV AAFP Scientific Assembly, Charleston.

April 22-30—Am. College of Obstetricians & Gynecologists, Las Vegas.

April 26-29—WV Academy of Ophthalmol. & Otolaryngol., White Sulphur Springs.

May 16-20—Ohio State Med. Assn., Cleveland.

June 7-11—AMA House of Delegates, Chicago.

**Aug. 20-22—114th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.**

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Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). Ⓒ III

**For the millions of patients who need the potency of aspirin and codeine for their acute pain.**

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**DESCRIPTION**: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths No 2 — 15 mg, No 3 — 30 mg, and No. 4 — 60 mg (Warning — may be habit-forming)

**CONTRAINDICATIONS**: Hypersensitivity to aspirin or codeine.

**WARNINGS**:

**Drug dependence**: Empirin with Codeine can produce drug dependence of the morphine type and, therefore, has the potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degree of caution appropriate to the use of other oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to the Federal Controlled Substances Act

**Use in ambulatory patients**: Empirin with Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery The patient using this drug should be cautioned accordingly.

**Interaction with other central nervous system (CNS) depressants**: Patients receiving other narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomitantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, the dose of one or both agents should be reduced

**Use in pregnancy**: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards

**PRECAUTIONS**:

**Head injury and increased intracranial pressure**: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Furthermore, narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute abdominal conditions**: The administration of Empirin with Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

**Allergic**: Precautions should be taken in administering salicylates to persons with known allergies: patients with nasal polyps are more likely to be hypersensitive to aspirin.

**Special risk patients**: Empirin with Codeine should be given with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostatic hypertrophy or urethral stricture, peptic ulcer, or coagulation disorders.

**ADVERSE REACTIONS**: The most frequently observed adverse reactions to codeine include light-headedness, dizziness, sedation, nausea and vomiting These effects seem to be more prominent in ambulatory than in nonambulatory patients and some of these adverse reactions may be alleviated if the patient lies down Other adverse reactions include euphoria, dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsiness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin. Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested by a skin rash or even an anaphylactic reaction. With these exceptions, most of the side effects occur after repeated administration of large doses.

**DOSAGE AND ADMINISTRATION**: Dosage should be adjusted according to the severity of the pain and the response of the patient It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain or in those patients who have become tolerant to the analgesic effect of narcotics. Empirin with Codeine is given orally. The usual adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual adult dose for Empirin with Codeine No. 4 is one tablet every four hours as required.

**DRUG INTERACTIONS**: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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# WVU Medical Center
# –News–

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## B-Plus Average Achieved By Entering Class

The entering class at the School of Medicine this fall averaged a high B-plus in its overall grades for previous college and university work.

Dean John E. Jones, M. D., said the cumulative grade-point average on a 4-point system, with 4 meaning A, was 3.58. For science courses alone, the grade-point average was 3.5.

Doctor Jones said the statistical analysis was based on the class of 88 accepted effective June 1. A few substitutions were made before classes started August 25, but they would not affect the averages appreciably.

A total of 327 persons submitted written applications for the class of 1980, and 255 were selected for interviews. Doctor Jones noted that all 202 of the West Virginia residents who applied were interviewed.

Sixty-eight per cent of the applicants had majored in biological sciences or chemistry, while no other field had more than three per cent of the total.

Occupations of the entering class's parents or guardians included 19 per cent in business, 16 per cent in professions other than medicine, and 11 per cent each for medicine, engineering, trades and crafts, or retired. Eighteen per cent listed "other" which included government and clerical workers.

Sixty-five of the 88 are males, and 84 are West Virginia residents. Fifty-five were 19 to 21 years old, 18 were 22 or 23, eight were 24 or 25, and seven were 26 or older.

Twenty-seven of the 88 attended college outside West Virginia, including three from Duke University, two each from Notre Dame and Vanderbilt, and the remainder from 20 other colleges and universities.

Of the 61 who went to college in West Virginia, 39 attended WVU, four each went to Marshall and West Virginia Wesleyan, three each to Bethany, Shepherd and Wheeling, two to Alderson-Broaddus and one each to Charleston, Concord and Glenville.

## Two Physicians Join Staff Of Nephrology Section

Two physicians have joined the faculty of the section of nephrology.

Lawrence Y. C. Agodoa, M. D., Associate Professor of Medicine, is a graduate of State College of Iowa in Cedar Falls and Cornell University Medical College.

He received his postgraduate training in internal medicine and nephrology at the University of Washington, and later was a member of the clinical faculty of that institution while serving as Chief of the Nephrology Service at Madigan Army Medical Center in Tacoma.

Aaron Spital, M. D., Assistant Professor of Medicine, is a graduate of City College of New York and the Medical College of Wisconsin.

He received his training in internal medicine at New York Medical College and Tufts University, and was a Fellow in nephrology at Brown University School of Medicine.

## Doctor Renn Returns To Faculty As Associate Professor

Joseph J. Renn III, M. D., has joined the faculty as an Associate Professor of Medicine.

Doctor Renn is returning to the section of pulmonary diseases where he completed a fellowship in 1972.

A graduate of the WVU School of Medicine, he interned at the University of Virginia and took residency training in internal medicine at the University of North Carolina and WVU.

He has been in the private practice of internal medicine and pulmonary diseases in Morgantown for the past eight years, and has served as Chief of Medicine and Chief of Staff at Monongalia General Hospital.

# In G.I. therapy

# Adjunctive Librax®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

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## for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

## Librax®

**Please consult complete prescribing information, a summary of which follows:**

**Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation; extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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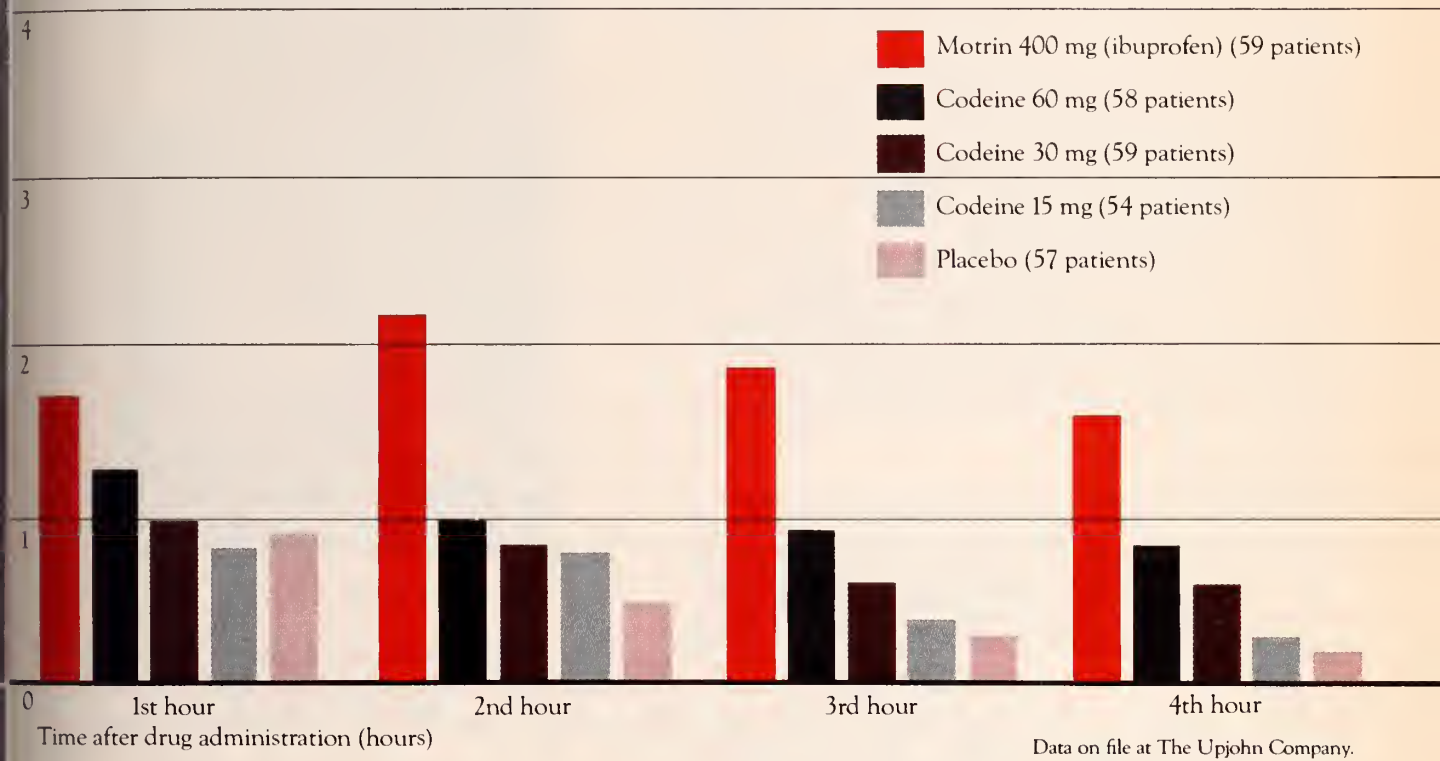
# compare the analgesic effect

*Motrin* (ibuprofen) 400 mg tablets provided greater relief of pain than codeine in a double-blind, randomized clinical study of 287 patients.
*Motrin* was significantly more effective ($p < 0.01$) than codeine 60 mg at the 2-, 3- and 4-hour intervals...significantly more effective ($p < 0.01$) than codeine 30 mg, codeine 15 mg, and placebo at all intervals.

**Degree of pain relief—mean scores**

4 = Excellent relief  3 = Good relief  2 = Fair relief  1 = Poor relief  0 = No relief

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**A well-tolerated, nonnarcotic prescription for mild to moderate pain**

**Motrin® 400 mg TABLETS**

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- Not a narcotic • Not addictive • Not habit forming • Acts peripherally
- Relieves pain rapidly • Indicated in acute and chronic pain • Well tolerated
- The most common side effect with *Motrin* is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

**Upjohn**

# Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

**Motrin® Tablets** (ibuprofen, Upjohn)

**Indications and Usage:** Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

**Contraindications:** Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

**Warnings:** Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

**Precautions:** Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

**Drug interactions.** *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

**Pregnancy and nursing mothers:** Motrin should not be taken during pregnancy or by nursing mothers.

**Adverse Reactions**

*Incidence greater than 1%*

**Gastrointestinal:** The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

*Incidence less than 1 in 100*

**Gastrointestinal:** Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

*Causal relationship unknown*

**Gastrointestinal:** Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

**Overdosage:** In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

**Dosage and Administration:** Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

**Caution:** Federal law prohibits dispensing without prescription.

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May 1980



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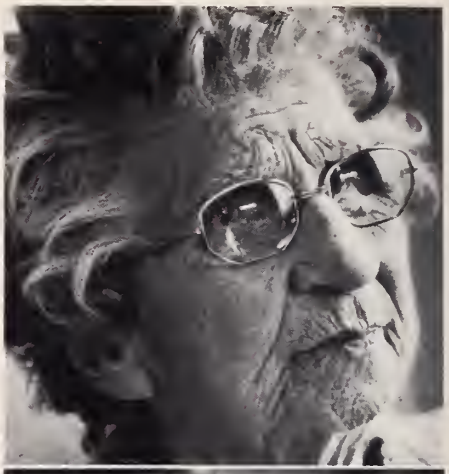

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Gentlemen:

I understand that a full time service representative of our Association covers the State for personal consultation and claims service. Please send me additional information on the following:

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  Pays your office expense up to $3,500 per mo while you are disabled
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  Covers: Malpractice — Home — Personal — Auto Liability

Name _____

Address _____ Phone # _____

# Third-Party News, Views and Program Concerns

## Open Letter

*Here is an open letter to physicians from Gretchen O. Lewis, West Virginia's Workmen's Compensation Commissioner:*

It certainly was a pleasure to meet with the Council of the State Medical Association, its Section on Orthopedic Surgery, and to visit personally with many of you at the Association's Annual Meeting in August. Thank you for the opportunity to share my views and exchange ideas openly with your leadership.

I am delighted to report that the response to our plea for examiners has been great and immediate. Since the meeting in August, I have appointed 25 new medical examiners for the Fund.

Following is the Fund's new policy regarding consultations requested by physicians. We feel that this approach will facilitate more timely medical care for injured workers, eliminate administrative paperwork and delay in the Fund as well as your office, and will allow better claims management from our viewpoint. All employers and medical vendors will be apprised of this policy change by letter. Note that this does not change existing procedure that prior authorization be requested for the change of treating physician, treatment by other than the physician of record, and hospitalization/surgical intervention.

NEW CONSULTATION POLICY
Effective November 1, 1980

If, in the opinion of the treating physician of record, a consultation (examination only) is deemed advisable in relation to the compensable injury, the treating physician may, without prior authorization, arrange the consultation, provided the consulting physician is located within 100 miles of the claimant's residence. However, the treating physician, upon arranging the consultation, must immediately notify the fund of the referral by narrative report outlining the claimant's condition and the reason a consultation is desired. It also is necessary that the consultant provide the Fund with a narrative report of the findings and recommendations.

Sincerely,

Gretchen O. Lewis
Commissioner

## 21 Per Cent Of State's People Get Social Security

In West Virginia, there are 399,750 Social Security beneficiaries who receive monthly Social Security benefits amounting to more than $89,949,000, or $1,059,049,000 per year.

These figures are among statistical data in a report released recently by the Social Security Administration, U. S. Department of Health and Human Services.

The Social Security beneficiaries in West Virginia represent 21 per cent of the state's population, according to the report.

Other benefits being received in West Virginia, with the number of persons and annual dollar amounts shown, are:

Retirement, 150,132 and $460,577,000; disability, 38,990 and $155,269,000; survivors, dependents and special, 168,142 and $377,749,000; and aged, blind and disabled, 42,487 and $65,454,000.

In addition to the above regular Social Security programs, Social Security also administers the Black Lung Benefits Section of the Federal Coal Mine Health and Safety Act. Under this law, there are 73,933 beneficiaries who receive $14,625,000 monthly.

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A. M. Fuller, M. D.
F. A. Khan, M. D.

**FAMILY PRACTICE:**
L. H. Valliant, M. D.
H. E. W. Gregor, M. D.

**INTERNAL MEDICINE:**
**Gastroenterology:**
S. S. Masilamani, M. D.
**Allergy & Rheumatology:**
J. B. Magee, M. D.
**Cardiology:**
H. L. Jellinek, M. D.
P. W. Gregor, M. D.
**Metabolic & Endocrine Diseases:**
F. Becerra, M. D.
**Pulmonary Diseases:**
J. C. Arnett, Jr., M. D.

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J. F. de Courten, M. D.
J. J. Rizzo, M. D.
M. W. Strider, M. D.

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B. R. Blackburn, M. D.
R. A. Rose, M. D.

**UROLOGY:**
D. T. Chua, M. D.

# Obituaries

## ARTHUR L. OSTERMAN, M. D.

Dr. Arthur L. Osterman, Wheeling psychiatrist, was found beaten to death in his office on October 1. He was 77.

Doctor Osterman was on the staffs of the Ohio Valley Medical Center, Inc., and Wheeling Hospital.

A native of Monroe, Louisiana, he was graduated from the University of Arkansas and received his M. D. degree in 1927 from that institution's School of Medicine. Further training was taken at the Podzl Clinic in Vienna, Austria, under Dr. Manfred Sakel, the discoverer of insulin shock therapy.

He served residencies at the Neurological Institute in New York City, St. Vincent's Infirmary in Little Rock, and the Ohio Valley Medical Center.

For 14 years—1927-1941—he was the only psychiatrist in West Virginia.

Doctor Osterman was a life member of the American College of Physicians and the American Psychiatric Association, a Fellow of the New York Academy of Science, and a member of the American Association for the Advancement of Science and the Central Neuropsychiatric Association.

He also was an honorary member of the Ohio County Medical Society, West Virginia State Medical Association and American Medical Association.

He was a World War II Navy veteran.

Surviving are the widow; a son, Dr. A. Lee Osterman of Philadelphia; a sister, Mrs. Lillian Kelley of Silver Spring, Maryland, and a brother, Frank Osterman of Houston, Texas.

* * *

## ARTHUR A. SMITH, M. D.

Dr. Arthur A. Smith of Charleston, formerly of Clay, died on October 6 in a Charleston hospital. He was 92.

Clay County's only practicing physician for 40 years (1930-1970), he previously practiced in Morrisvale (Boone County).

Doctor Smith was a graduate of Valparaiso (Indiana) University and received his M. D. degree in 1915 from the Chicago College of Medicine and Surgery (now Loyola University).

He was an honorary member of the Kanawha Medical Society, West Virginia State Medical

(Continued on Page xvi)




**CYCLAPEN®-W** (cyclacillin)

**Indications**
*Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications.* Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, nonpenicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.
**Contraindications** Contraindicated in individuals with history of an allergic reaction to penicillins.
**Warnings** **Cyclacillin should only be prescribed for the indications listed herein.**
**Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.**
**Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.**
**Precautions** Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.
**Adverse Reactions** Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 months of age.
*Patients with Renal Failure* Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
**Dosage** (Give in equally spaced doses)

| INFECTION | ADULTS | CHILDREN* |
|---|---|---|
| *Respiratory Tract* | | |
| Tonsillitis & Pharyngitis | 250 mg q.i.d. | body weight ≤ 20 kg (44 lbs) 125 mg q.i.d.<br>body weight > 20 kg (44 lbs) 250 mg q.i.d. |
| Bronchitis and Pneumonia | | |
| Mild or Moderate Infections | 250 mg q.i.d. | 50 mg/kg/day q.i.d. |
| Chronic Infections | 500 mg q.i.d. | 100 mg/kg/day q.i.d. |
| Otitis Media | 250 mg to 500 mg q.i.d.† | 50 to 100 mg/kg/day† |
| Skin & Skin Structures | 250 mg to 500 mg q.i.d.† | 50 to 100 mg/kg/day† |
| *Urinary Tract* | 500 mg q.i.d. | 100 mg/kg/day |

*Dosage should not result in a dose higher than that for adults
†depending on severity

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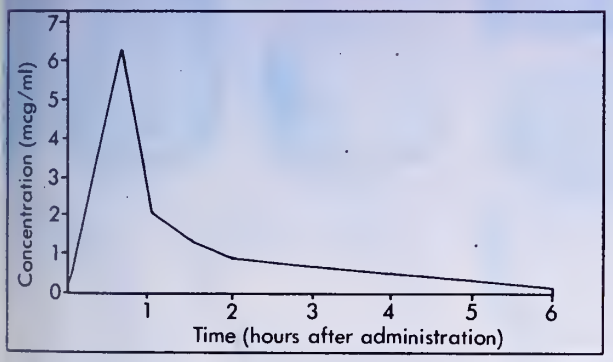


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|---|---|---|
| Causative Organism | Branchitis/Pneumonia† | No. of Patients |
| *S. pneumaniae* | 100% | 73 |
| | 95% | |
| Chronic Bronchitis† (acute exacerbation) | | |
| *H. influenzae* | 92% | 12 |
| | Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*. | |
| Streptococcal Sore Throat† | | |
| Group A beta-hemolytic Streptococcus | 100% | 44 |
| | 86% | |
| % Clinical Response<br>% Bacterial Eradication | | |

†Due to susceptible organisms.

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# County Societies

### CABELL

The Cabell County Medical Society met jointly with the Cabell County Bar Association on September 11 at the Huntington Civic Center.

Governor John D. Rockefeller IV was the speaker. Following his formal address, he answered questions which dealt with items of special interest, including Workmen's Compensation laws, development of adequate access roads to the Basic Sciences/Medical Education Building of the Marshall University School of Medicine now under construction at the Huntington Veterans Administration Medical Center, and the composition of Blue Cross/Blue Shield boards. —Charles E. Turner, M. D., Secretary.

* * *

### LOGAN

The Logan County Medical Society met on September 10 at Logan General Hospital.

The guest speaker was Thomas Auman of Charleston, Account Supervisor for Aetna Life & Casualty, carrier for the State Medical Association's malpractice insurance program.

Auman offered numerous valuable suggestions for minimizing the risk of malpractice litigation, with emphasis on the value of accurate medical records.—Herbert D. Stern, M. D., Secretary.

* * *

### HARRISON

Dr. L. Walter Fix of Martinsburg, President of the State Medical Association, was honor guest for the meeting of the Harrison County Medical Society on September 4.

The educational program was presented by Dr. Amar Segrea of Shadyside Hospital in Pittsburgh. His subject was "Dilatation Angiography."—Carlos A. Naranjo, M. D., Secretary.

* * *

### MARION

Dr. L. Walter Fix of Martinsburg was the guest speaker for the meeting of the Marion County Medical Society on September 30 at the Fairmont Field Club.

Doctor Fix, President of the State Medical Association, discussed the changing spectrum of medical practice and the problem with medical malpractice insurance in the state.

He also emphasized the need to support the American Medical Association, and to increase our membership in the AMA.—William L. Mossburg, M. D., President.

### McDOWELL

Dr. Krishna J. Gravois presented the medical program for the meeting of the McDowell County Medical Society on September 10 at the Stevens Clinic Hospital in Welch.

Doctor Gravois, radiologist at the Hospital, covered radioisotope scanning and the use of technetium.—Muthusami Kuppusami, M. D.

* * *

### PARKERSBURG ACADEMY

Dr. John McSorley from the University of Pittsburgh was the guest speaker for the meeting of the Parkersburg Academy of Medicine held on September 10 at the Parkersburg Country Club.

His topic was "Cutaneous Manifestations in Systemic Diseases."

Dr. Harry Shannon gave a report on the last meeting of the Council of the State Medical Association.—Bill M. Atkinson, M. D., Secretary-Treasurer.

* * *

### MINGO

The Mingo County Medical Society met on September 10.

A report on the activities of the State Medical Association at its Annual Meeting was given.

There was intensive discussion on the work of the Association's Ad Hoc Committee on Professional Liability, and the efforts of the Association in this regard were vigorously approved.—Edward B. Headly, M. D., Secretary.

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OBITUARIES—*Continued*

Association( becoming a member in 1922), and the American Medical Association.

Doctor Smith was a former Clay County Coroner, and was a 25-year member of the Clay Selective Service Board.

Survivors include the widow; a daughter, Mrs. Charlotte Schoonover of Spring Hill (Kanawha County); two sons, Harry C. Smith of London, Ohio, and Arthur L. Smith of Charleston; a sister, Mrs. Stella Harper of Zephyrhills, Florida, and two brothers, Perry Smith of South Point, Ohio, and Frederick Smith of Bomont (Clay County).

* * *

### ARNOLD C. BURKE, M. D.

Dr. Arnold C. Burke, South Charleston pediatrician, died on October 4 at his home in Charleston. He was 54.

Doctor Burke, who had practiced in South Charleston for 18 years, was Chief of Pediatrics

(Continued on next Page)

# Book Review

**GENERAL OPHTHALMOLOGY** — Daniel Vaughan, M. D.; and Taylor Asbury, M. D. 410 pages. Price $15. Lange Medical Publications, Los Altos, California. 1980.

The Ninth Edition of this paperback text is intended to serve as a "review of the subject for medical students, ophthalmology residents, and our colleagues in other fields of medicine and surgery."

The general text is an easy-to-read, quick introduction to ophthalmology. I feel it would be beneficial for every medical student and resident to include it in their libraries.

The chapter on examination and the first appendix are excellent presentations of the basic ophthalmic examination. Together, the fourth chapter (Principles of Management of Common Ocular Disorders) and the appendix on eye medications are adequate in preparing medical students for their first ophthalmic rotation.

The chapter dealing with glaucoma is not as thorough as needed, and mentions on page 166 that timolol maleate is a medication to be given orally instead of its proper topical route. The chapter also fails to discuss timolol's possible adverse systemic effects.

Doctors Vaughan and Asbury included in this edition the use of CT scanning for differential diagnoses. Located in the appendix, it was a short section, but concise in the way it was presented.

This is one of Lange Medical Publications' better texts. I believe if the buyer would use it as the authors intended, a general introduction, he would find the reading to be well worth his time. — Daniel F. Miller, M.D.

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**CURRENT MEDICAL DIAGNOSIS AND TREATMENT**—by Marcus A. Krupp, M. D., and Milton J. Chatton, M. D., 1116 pages. Price $19. Lange Medical Publications, Los Altos, California 94022. 1980.

As evidence of its merit and success, this book has appeared in 19 editions since its inception in 1962. Its international acceptance is evidenced by the fact that it has been published in Spanish, Italian, Japanese, Greek, and other European languages. The editors have succeeded admirably in providing ready access to a wide range of medical and paramedical topics, many of which are not otherwise available in one publication. Although the emphasis is towards the general practitioner because of the subject matter, I am sure this book also will appeal to the other specialists practicing primary care medicine in the United States. There is an important contribution on poisons and immunologic disorders. The appendices, which range from the problem-oriented record and CPR to emergency treatment of food-choking, enhance the usefulness and reference value of this book.

In Chapter One, "Addison's disease" as a cause of fever also should have been included.

In Chapter Four, on the eye, many common drugs like Beta-Blockers and disopyramide were omitted from the table of systemic drugs having adverse ocular effects, but again one does not expect this book to be an encyclopedia. Perhaps the authors thought these side effects were too rare to mention.

I believe strongly that EKG illustrations in Chapter Seven, "Heart and Great Vessels," would have been very helpful in enhancing the value of this book as a desk reference. It also should be pointed out that disopyramide intravenous preparation is not freely available in this country, which might disappoint some readers.

The text is easy to read and grasp and, as always, the standards of production and illustrations are high. The bibliographies are up-to-date.

This is an excellent book which fulfills its intended purpose as a useful desk reference. At this price it is a bargain. I enthusiastically recommend it to medical students, house staff, and primary care physicians who wish to maintain their interests in the full range of art and science. —Saeed Ahmad, M. D.

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OBITUARIES—*Continued*

at Herbert J. Thomas Memorial Hospital there. He previously was located in Beckley and Seth (Boone County).

A native of Birmingham, Alabama, he was graduated from Alabama Polytechnic Institute and received his M. D. degree in 1954 from the Medical College of Alabama.

Doctor Burke, a World War II Navy veteran, was a member of the Kanawha Medical Society, West Virginia State Medical Association, American Medical Association and West Virginia Chapter, American Academy of Pediatrics.

Survivors include the widow; a daughter, Miss Lee Ann Burke, at home; a son, William A. Burke, at home; the parents, Mr. and Mrs. James L. Burke of Dozier, Alabama, and a brother, James R. Burke of Hugheytown, Alabama.

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**Warnings:** Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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| Pheniramine Maleate | 20 mg |
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| Hyoscyamine Sulfate | 0.19 mg |
| Atropine Sulfate | 0.04 mg |
| Scopolamine Hydrobromide | 0.01 mg |

Ru-Tuss Tablets act continuously for 10 to 12 hours
Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

**INDICATIONS AND USAGE** Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

**CONTRAINDICATIONS** Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

**WARNINGS** Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

**PRECAUTIONS** Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

**OVERDOSAGE** Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

**ADVERSE REACTIONS** Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

**DOSAGE AND ADMINISTRATION** Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

**HOW SUPPLIED:**

| | |
|---|---|
| Bottles of 100 Tablets | NDC 0524-0058-01 |
| Bottles of 500 Tablets | NDC 0524-0058-05 |

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# COUGH

# RU-TUSS® EXPECTORAN

DESCRIPTION
Each fluid ounce of Ru-Tuss Expectorant contains

| | |
|---|---|
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| (WARNING. MAY BE HABIT FORMING) | |
| Phenylephrine Hydrochloride | |
| Phenylpropanolamine Hydrochloride | |
| Pheniramine Maleate | |
| Pyrilamine Maleate | |
| Ammonium Chloride | 2 |
| Alcohol | |

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

**INDICATIONS AND USAGE** Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

**CONTRAINDICATIONS** Hypersensitivity to antihistamines. Concomitant use of a monoamine oxidase inhibitor, hypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.
Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

**WARNINGS** Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

**PRECAUTIONS** Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease. Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

**ADVERSE REACTIONS** Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness and insomnia. Overdose may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, tachycardia and even convulsions.

**DOSAGE AND ADMINISTRATION** Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.
Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: ½ teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directed by a physician.

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# CONTENTS

**Scientific Articles**

Urinoma Formation Secondary to Tumor Obstruction of the Ureter — Robert P. Cricco, M. D.; David J. Lindert, M. D.; and Bradford McCuskey, M. D. ... 311

Pseudo-Eccyesis: Hemoperitoneum Associated with Corpus Luteum Hemorrhage and Anticoagulant Therapy — John W. Durkin, Jr., M. D. ... 315

1980 Van Liere Memorial Student Research Convocation, WVU School of Medicine ... 317

**The President's Page**

Doctor, Are You in Shape? — Ruth (Mrs. Gary G.) Gilbert, President, Auxiliary to the W. Va. State Medical Association ... 324

**Editorials**

Minority Views ... 325
Sections, Societies ... 325
A Real Bargain ... 326

**General News**

14th Mid-Winter Clinical Conference ... 327
Auxiliary Review Includes Fayette Project ... 329
Association Awards Medical Scholarship ... 329
Review a Book ... 329
AMA Winter Meeting in January ... 330
State EENT Group Sets Spring Meeting ... 330
Medical Women to Meet April 4 ... 330
AMA Sports Medicine Conference ... 331

**Special Departments**

WVU Medical Center News ... x
Third-Party News, Views, Program Concerns ... xii
Obituaries ... xiv
County Societies ... xvi
1980 Annual Index ... xxii
Classified Section ... xxvi
Index To Advertisers ... xxviii

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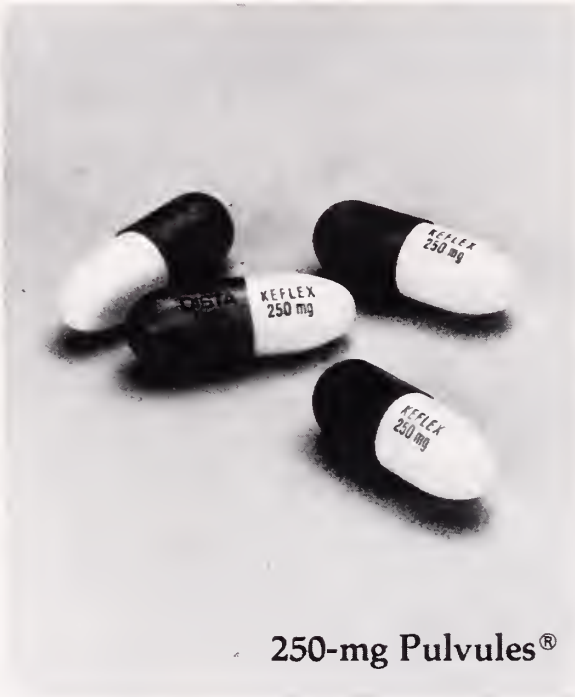


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"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

**CONTRAINDICATIONS**: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

**WARNINGS**: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination

**USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.**

**Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered**

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under

**PRECAUTIONS**: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

**ADVERSE REACTIONS**: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

**OVERDOSE**: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

**DESCRIPTION**: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

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**WYGESIC—Abbreviated Summary**

**INDICATION:** For the relief of mild-to-moderate pain.

**CONTRAINDICATION:** Hypersensitivity to propoxyphene or to acetaminophen.

**WARNINGS:** CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

**DRUG DEPENDENCE:** Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

**USAGE IN AMBULATORY PATIENTS:** Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

**USAGE IN PREGNANCY:** Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

**USAGE IN CHILDREN:** Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

**PRECAUTIONS:** Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

**ADVERSE REACTIONS:** The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

**DRUG INTERACTIONS:** Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

**MANAGEMENT OF OVERDOSAGE:** SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

**TREATMENT:** Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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# Urinoma Formation Secondary To Tumor Obstruction Of The Ureter

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*Peripelvic extravasation of urine is quite rare and usually associated with renal trauma or obstructing calculi. Spontaneous extravasation with associated urinoma formation is even more rare and usually is due to chronic obstruction of the urinary system.*

*A case of spontaneous extravasation with urinoma formation secondary to tumor obstruction of the ureter is presented. The clinical features and management of urinoma formation also are discussed.*

Urinary extravasation rarely is seen on excretory urography. When it does occur, it usually is due to obstruction with secondary rupture of the collecting system in the light of persistent renal function. Urinary extravasation with subsequent urinoma formation is seen most commonly following renal trauma. However, increasing numbers of cases of spontaneous extravasation secondary to obstructing calculi are being seen with the increasing use of concentrations of contrast medium. It is very unusual to see spontaneous urinary extravasation with urinoma formation secondary to tumor obstruction of the ureter.[1]

**Case Report**

G.C., a 72-year-old, white male presented with increasing symptoms of prostatism and right lower quadrant and flank pain associated with nausea and vomiting. Physical examination revealed a large mass in the right flank extending into the right lower quadrant. Rectal examination revealed a diffusely rock-hard prostate gland with extension to both seminal vesicles and the base of the bladder. Post-void-

**Figure 1. KUB revealing a soft tissue mass on the right side with obliteration of the psoas margin.**

ing residual urine was 125 cc. Laboratory studies revealed a BUN of 22, a creatinine of 1.9, a normal acid phosphatase, and a urinalysis showing numerous red blood cells with 6-8 white blood cells. Urine culture showed no growth in 48 hours.

Intravenous urogram revealed dilatation of the collecting system and both ureters. Extravasation of contrast material from the region of the renal pelvis on the right was noted (Figures 1 and 2). On delayed films a large, contrast-filled urinoma measuring 23 x 13 cm. was seen (Figure 3). The hydronephrosis appeared to be secondary to obstruction at the ureterovesical junction bilaterally. Bone scan revealed prominent activity in the region of the right kidney corresponding to the urinoma noted on the urogram (Figure 4). In addition, a solitary lower cervical abnormality was noted. Abdominal ultrasound revealed the right kidney to be markedly displaced anterolaterally by the large urinoma lying against the undersurface of the anterior peritoneum (Figure 5).

The patient subsequently underwent transurethral resection of the prostate with pathology revealing poorly-differentiated adenocarcinoma. He also underwent extraperitoneal drainage of the urinoma of approximately 2000 ml. of urine. The very distal right ureter was encased in tumor deep in the pelvis. Attempts at passage of both retrograde and antegrade ureteral catheters were unsuccessful; therefore, the ureter was resected distally and the normal ureter was reimplanted into the bladder using a Gibbons permanent indwelling catheter as a stent.

The patient did well postoperatively with follow-up intravenous urogram revealing significant diminution of the hydronephrosis and resolution of the urinoma (Figure 6). He subsequently underwent palliative bilateral orchiectomy.

**Figure 2. Intravenous urogram with delayed film revealing dilatation of the collecting system bilaterally to the level of the ureterovesical junction. Extravasation of contrast medium from the region of the right pelvis also is noted.**

### Discussion

Schwartz has defined spontaneous extravasation as the collection of urine outside the urinary tract in the absence of recent ureteric instrumentation, previous surgery, trauma, destructive renal lesion, urography with external compression or pressure necrosis by stones.[2] The most common site for extravasation to occur is at the calyceal fornix where a tear secondary to increased intrapelvic pressure leads to disruption of the fornix with subsequent backflow into the renal sinus and extravasation about the kidney.

The development of a urinoma will continue as long as the obstruction is not relieved. Pre-

**Figure 3. On the 24-hour film a large, contrast-filled urinoma is seen.**

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**Contraindications:** Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired.** If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum $K^+$ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict $K^+$ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum $K^+$ frequently; both can cause $K^+$ retention and elevated serum $K^+$. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

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**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

**PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of non susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

**ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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vious anatomic studies[3] have shown that the kidney is completely enclosed by the perirenal (Gerota's) fascia; and, within these boundaries a urinoma would be confined. The continued collection of urine stimulates an intense inflammatory reaction leading to the formation of its pseudocapsule.

The diagnosis of urinoma is not usually difficult. The patient usually presents with renal colic, abdominal pain and a palpable flank mass. Nausea and vomiting, weight loss, voiding symptoms, occasionally hematuria, and rarely hypertension may be present.[4] In the presence of a normal contralateral kidney, renal function is not usually compromised.

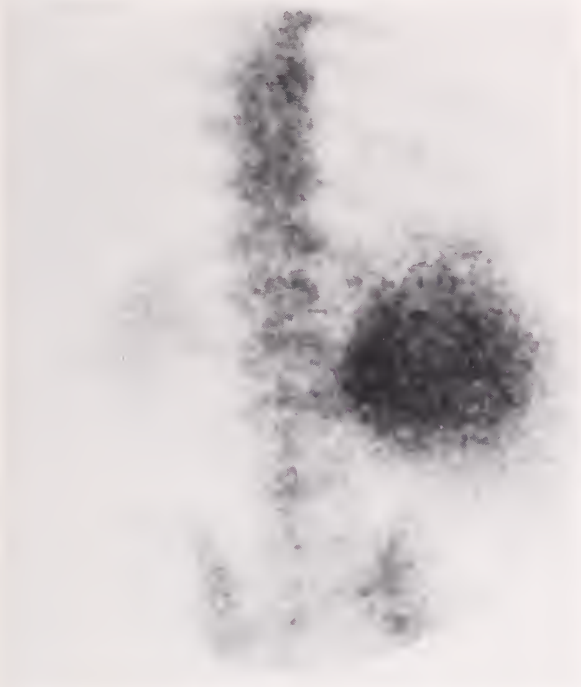

**Figure 4. Bone scan reveals prominent activity in the region of the right kidney corresponding to the urinoma noted on the urogram.**

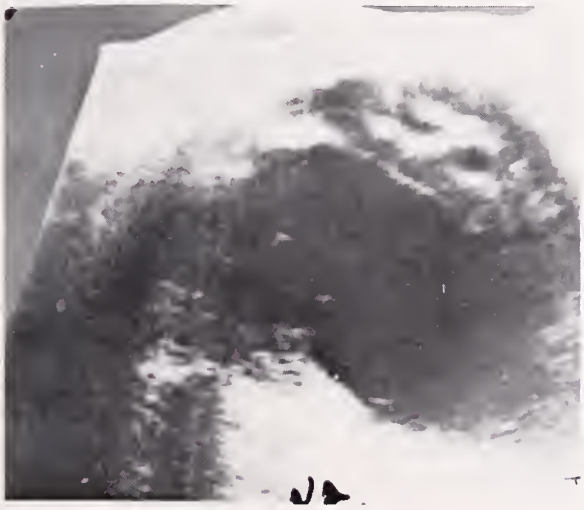

**Figure 5. Ultrasound showing the large urinoma displacing the right kidney anterolaterally.**

Plain films of the abdomen will reveal loss of the psoas shadow and the presence of a soft tissue mass. Calcifications are rarely seen. Drip infusion pyelography will reveal many features of obstruction. In addition, extravasation from calyceal fornices extending through the renal sinus and down around the ureter will be apparent. Delayed films will reveal the extent of the contrast-filled urinoma.

Perirenal extravasation localizes according to the effects of gravity and the planes of least resistance. Therefore, the mass usually is elliptical, oriented inferomedially with upward and lateral displacement of the lower pole of the kidney along with medial displacement of the ureter.[5] Extravasation rarely occurs outside the confines of the perirenal fascia except with renal trauma, and in this situation urgent surgical therapy is required.

Retrograde pyelography usually has not been helpful in defining the point of obstruction. It also adds the risk of infection of the urinoma. Arteriography demonstrates a non-vascular mass. Ultrasound appears to be extremely helpful in defining the borders of the fluid-filled mass. In

**Figure 6. Postoperative urogram revealing significant diminution of the hydronephrosis on the right with resolution of the urinoma. A Gibbons permanent indwelling ureteral catheter also is noted.**

fact, should renal function be inadequate for diagnosis, ultrasound with needle aspiration is the diagnostic procedure of choice.[4]

Simple drainage of the urinoma usually is inadequate due to the persistence of the obstruction. Nephrostomy, drainage of the urinoma, and intubation of the repaired ureter if the obstruction can be bypassed appear to be most adequate method of treatment.[6] Depending on the etiology of the obstruction, relief also may be obtained with irradiation, chemotherapy or hormonal therapy. Rarely will retrograde passage of a ureteral catheter be successful in light of the degree of obstruction usually present.

The obstruction within the urinary tract must be relieved or the urinoma is sure to recur. Once the obstruction has been relieved and adequate drainage established, there should be rather prompt resolution of radiographic abnormalities. With the loss of renal function secondary to obstruction, nephrectomy should be done if there is normal contralateral kidney.

### Conclusions

Spontaneous extravasation of urine is quite rare and usually is due to an obstructing calculus. When spontaneous extravasation is seen associated with urinoma formation, chronic obstruction of the urinary system is the usual cause, and obstruction secondary to tumor should be considered. Relief of the obstruction is of paramount importance, as simple drainage will only lead to reformation of the urinoma.

### References


1. Twersky J, Twersky N, Phillips G, Coppersmith H: Peripelvic extravasation, urinoma formation and tumor obstruction of the ureter. *J Urol* 116: 305-307, 1976.

2. Schwartz A, Caine M, Hermann G, Bittermann W: Spontaneous renal extravasation during intravenous urography. *Am J Roentgen* 98: 27, 1966.

3. Mitchell GAG: The renal fascia. *Brit J Surg* 37: 257-266, 1950.

4. McInerney D, Jones A, Roylance J: Urinoma. *Clin Radiol* 28: 345-351, 1977.

5. Meyers MA: Uriniferous perirenal pseudocyst; new observations. *Radiol* 117: 539-546, 1975.

6. Hurwitz SP, Weisenthal CL: Pararenal pseudocyst. *J Urol* 97:8-15, 1967.


## Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (no onion skin or flimsy), standard letter sized (8 ½ by 11 in.) white paper. Wide margins (at least 1 ¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing the most commonly known trade-name drug of that designation. In addition, a listing of all generic drugs mentioned in the article, with their trade-name equivalents, should appear at the end of the article.

A short abstract summarizing the manuscript should be included. This should be typed in double space on a separate page.

Authors are requested to submit a carbon copy with the original.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for reproduction should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

# Pseudo-Eccyesis: Hemoperitoneum Associated With Corpus Luteum Hemorrhage And Anticoagulant Therapy

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*Chairman, Department of Obstetrics and Gynecology, Wheeling Division, West Virginia University School of Medicine and Ohio Valley Medical Center, Inc.*

*A diagnosis of ectopic pregnancy should be considered when abdominal symptoms are presented by women of reproductive age. Of those women, however, any using anticoagulant therapy also should be suspected of hemorrhaging from a corpus luteum. The following is a case in point.*

When a woman of reproductive age appears in the Emergency Room complaining of abdominal pain, the physician's differential diagnosis must always include ectopic pregnancy. Ectopic pregnancy remains as a potential, constant contributor to maternal mortality.

In the words of Gilbert and Sullivan, "All things are not what they seem; skim milk can masquerade as cream." So too another pelvic condition may mimic an ectopic pregnancy. This is illustrated by presentation of the following young lady's clinical problem.

### Case Report

A 17-year-old, single, Caucasian female visited the Emergency Room of the hospital in mid-morning with a complaint of vague abdominal discomfort. A rather casual medical history was elicited. The pelvic examination was unremarkable. The patient was reassured. A non-narcotic analgesic was prescribed for her while resting at home.

The abdominal discomfort increased, however, as the day progressed. While resting in bed, the patient began to notice bilateral shoulder pain, more marked on the right. She became increasingly weak, and nearly fainted while going to the bathroom. She returned to the same Emergency Room some 15 hours after her first visit.

A different physician saw her on this visit, and a more extensive history was taken. On day 25 of her menstrual cycle, she presented no irregularity in her cyclic pattern and vehemently denied any sexual exposure. Three years previously she had cardiac surgery at the West Virginia University Medical Center (Morgantown) with the insertion of a prosthetic aortic valve. She had continued under the care of a local cardiologist with maintenance medication consisting of Digitalis, Penicillin, and Coumadin.

Abdominal examination revealed diffuse findings with pain most marked in the right lower quadrant. Pelvic examination revealed a fullness in the cul-de-sac but no discrete masses. A cul-de-centesis obtained a copious amount of fresh blood. A diagnosis of hemoperitoneum, most likely due to a ruptured ectopic pregnancy in the right tube, was considered.

An exploratory laparotomy was undertaken immediately. This revealed two liters of fresh blood in the peritoneal cavity. The uterus was normal in size. Both uterine tubes and the left ovary were unremarkable. There was persistent, brisk bleeding from a corpus luteum on the right ovary. This was established as the only source of intraperitoneal bleeding.

The corpus luteum was excised easily and complete hemostasis established with a running, locked suture. An incidental appendectomy also was done and the operation completed by appropriate abdominal closure. Intraoperatively and postoperatively, the patient received about 900 ml. of packed red blood cells. She was continued on Digitalis, Penicillin and Coumadin without any difficulty. She returned home on her sixth postoperative day.

The patient is well some 18 months later. The periodic cardiac evaluations continue with maintenance on the same three drugs noted above. She continues to have regular menstrual cycles. Pelvic examinations and cervical cytology on two subsequent visits to the Gynecology Clinic have been within normal limits.

### Discussion

This patient illustrates at least three points. *First*, the physician must constantly be alert to a possible ectopic pregnancy in such a patient. This was not considered on her first visit to the Emergency Room. *Second*, we are seeing an increasing number of young women who have had cardiac surgery, usually for congenital heart disease. *Third*, most of these patients who had cardiac surgery are maintained on several drugs. Prominent among these drugs are anticoagulants.

It is realized that corpus luteum hemorrhage is a variant of the usual ovarian physiology. The majority of corpus lutea result in self-limited bleeding, escaping clinical recognition.[1,2] More extensive bleeding may warrant surgical intervention, but massive hemorrhage resulting in shock and death is not the usual outcome.[3-7]

Anticoagulant therapy may accentuate the possibility of corpus luteum hemorrhage, according to recent reports.[8-12] Although our patient did not display evidence of excessive anticoagulant activity, the drug may have contributed to the focal bleeding which progressed to a more extensive hemorrhage with hemoperitoneum.

We also have reviewed the records in this hospital during the preceding five years. There have been only six patients with the diagnosis of corpus luteum hemorrhage: one each year in 1973 through 1976 and two patients in 1977. The clinical findings in the latter two patients suggested hemoperitoneum probably due to an ectopic pregnancy, and resulted in laparotomy in each patient. Neither patient was using an anticoagulant. Both patients had hemoperitoneum (400 ml. and 1500 ml., respectively) due to a bleeding corpus luteum. Excision of the corpus luteum with hemostatic suturing resulted in uneventful recoveries in both patients.

This brings us back to the consideration of anticoagulant therapy in our patient who had cardiac surgery. There is accumulating literature on this subject documenting the propensity for severe corpus luteum hemorrhage with hemoperitoneum in this group of patients.[7-22] A variety of outcomes have been documented, ranging from continued reproduction[17] to loss of reproductive function[18] to death.[7, 14]

### Addendum

Subsequently, we retrieved evidence of another hospital admission for this patient approximately one year after her cardiac surgery. At that time she had been admitted, with similar symptoms (lower abdominal pain), through an Emergency Room. She was using Penicillin which was continued during her four days in the hospital. The working and final diagnoses were the same, acute pelvic inflammatory disease.

During that period she was afebrile, her WBC's were 9 x $10^3$ and 7 x $10^3$ on two occasions. Her hemoglobin and hematocrit were 11.0 Gm. (30 per cent) and 8.5 Gm. (25 per cent), respectively, on subsequent determinations in the hospital. The record notes she was on day 22 of her menstrual cycle, suggesting she may have had a corpus luteum hemorrhage on that occasion as well, rather than the above final diagnosis.

### Summary

We must continue to be alert for an ectopic pregnancy in any woman of reproductive age who presents with abdominal symptoms. We must, however, be aware that any women of the same age group, especially if she is using an anticoagulant, may suffer a severe, even fatal, hemorrhage from a corpus luteum.

### References


1. Novak E, Woodruff JD: *Novak's Gynecology and Obstetric Pathology: With Clinical and Endocrine Relations*, ed 7, Philadelphia, WB Saunders Co, p 335, 1974.
2. Taniguchi T, Kilkenny GS: Rupture of corpus lutem with production of hemoperitoneum. *JAMA* 147: 1420-1424, 1957.
3. Hoyt WF, Meigs JV: Rupture of the graafian follicle and corpus luteum. *Surg Gynecol Obstet* 62:114-117, 1936.
4. Israel SL: Ovarian rupture causing intraperitoneal hemorrhage with report of ten cases. *Am J Obstet Gynecol* 33:30-38, 1937.
5. Weil AM: Ruptured graafian follicle and corpus luteum with intra-abdominal hemorrhage simulating acute appendicitis and ruptured ectopic pregnancy. *Am J Obstet Gynecol* 38:288-295, 1939.
6. Fitzgerald JA, Berrigan MC: Accurate diagnosis of "Ovarian vascular accidents." *Obstet Gynecol* 13: 175-180, 1959.
7. Semchyshyn S, Zuspan FP: Ovarian hemorrhage due to anticoagulants. *Am J Obstet Gynecol* 131: 837-844, 1978.
8. Wesely AC, Neustadter MI, Levine W: Massive intraperitoneal hemorrhage of ovarian follicular origin during anticoagulant therapy. *Am J Obstet Gynecol* 73:683-685, 1957.
9. Gurewich V, Thomas D: Massive intraperitoneal hemorrhage from a ruptured corpus luteum: A rare complication of long term anticoagulant therapy. *N Engl J Med* 263:909-910, 1960.
10. Rosenthal AH: Rupture of the corpus luteum including four cases of massive intraperitoneal hemorrhage. *Am J Obstet Gynecol* 79:1008-1011, 1960.
11. Case Record of the Massachusetts General Hospital: 83-1962. *N Engl J Med* 267:1258-1262, 1962.
12. Dacus RM III: Massive intraperitoneal hemorrhage from a corpus luteum hematoma in women taking anticoagulants: Report of Two cases. *Obstet Gynecol* 31: 471-474, 1968.
13. Walton LA: Bleeding corpus luteum from anticoagulation therapy. *Obstet Gynecol* 33:450, 1969.
14. Sopher IM, Ming SC: Fatal corpus luteum hemorrhage during anticoagulant therapy. *Obstet Gynecol* 37:695-697, 1971.
15. Manny J, Merin G, Rozin RR *et al.*: Ovarian hemorrhage complicating anticoagulant theapy. *Obstet Gynecol* 41:512-514, 1973.
16. Matseone S, Batts JA Jr, Mandeville EO: Ovarian hemorrhage complicating warfarin sodium anticoagulant therapy. *Am J Obstet Gynecol* 124:766-767, 1976.
17. Winer HJ: Recurrent massive hemorrhage due to bleeding corpus luteum cyst. *Obstet Gynecol* 18:239-240, 1961.
18. Wong KP, Gillett PG: Recurrent hemorrhage from corpus luteum during anticoagulant therapy. *Can Med J* 116:388-390, 1977.
19. Lee RA, Kazmier FJ: Ovarian hematoma complicating anticoagulant therapy. *Mayo Clin Proc* 52:19-23, 1977.
20. Perlman JA, Barnes AB, Demirjian Z: Corpus luteum hemorrhages complicating chronic anticoagulation. *Obstet Gynecol* 49:205-215, 1977.
21. Waxman M, Baird GJ: Corpus luteum hemorrhage. Cause of acute abdominal pain in patients receiving anticoagulant therapy. *JAMA* 239:2270-2271, 1978.
22. Peters WA III, Thiagarajah S, Thornton WN Jr: Ovarian hemorrhage in patients receiving anticoagulant therapy. *J Reprod Med* 22:82-86, 1979.

# 1980 Van Liere Memorial Student Research Convocation, WVU School Of Medicine

THE Van Liere Memorial Research Convocation for Students in the West Virginia University School of Medicine was held on March 27, 1980. These yearly Convocations enable students in the School of Medicine to present the results of their research activities in competition for the Edward J. Van Liere Award.

This award, consisting of a plaque and a check for $100, was established in 1965 by action of the faculty of the School of Medicine to recognize the research efforts of our students and to honor the late Dr. Edward J. Van Liere, who served as Chairman of the Department of Physiology from 1921-1955 and as Dean of the School of Medicine from 1935-1961.

The 1980 convocation, the sixteenth, was the first one to be held since the death of Doctor Van Liere on September 5, 1979. In commemoration of Doctor Van Liere, the student research convocation has been named the Van Liere Memorial Research Convocation for Students in the School of Medicine.

The winner of the Edward J. Van Liere Award this year was Cynthia Olsen Jopling, a senior physical therapy student. The first runner-up and winner of a check for $50 was John R. Marler, Medicine IV, and the second runner-up and winner of a check for $25 was Barbara A. McQuinn, Medicine II. Samuel S. Thatcher, Medicine III, was ineligible to compete for the Van Liere Award because his research was done in partial fulfillment of the requirements for the Ph.D. degree.

The publication of the abstracts of the oral presentations in *The West Virginia Medical Journal* constitutes an important and greatly appreciated recognition of the research efforts of our students.

W. E. Gladfelter, Ph.D., *Chairman*
Van Liere Memorial
Research Convocation Committee

# Postoperative Pain Management: Transcutaneous Electrical Nerve Stimulation Versus Narcotics

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TRANSCUTANEOUS Electrical Nerve Stimulation (TENS) has been used postoperatively for the past five years. Investigators in the past have measured subjectively the effectiveness of TENS in pain management by comparing the amount of medication used in patients with and without TENS. By demonstrating that pulmonary function, as measured by spirometry, is an accurate measure of upper abdominal incision pain we were able objectively to: measure the success rates of TENS in managing postoperative pain; determine the placebo effect of TENS; and assess differences in the postoperative complications (e.g., atelectasis, ileus, pneumonia and pulmonary emboli) between TENS and narcotic pain management.

After receiving informed consent from an elective cholecystectomy patient of physical status I or II, the patient was randomized into one of three groups: conventional narcotics (Demerol PRN q 3-4 hours), TENS with batteries, and TENS without batteries. Preoperative values for peak expiratory flow rate, $FEV_1$, $FEV_3$, vital capacity, peak inspiratory flow rate, $FIV_1$, $FIV_3$, and respiratory rate were measured.

TENS electrodes were applied to the patient in the operating room and connected to the stimulator upon the patient's arrival at the recovery room. The stimulator settings for the functional TENS group were determined at the preoperative visit. As the patient regained consciousness he assumed control of the stimulation intensity. Pulmonary function values were measured again just prior to leaving the recovery

room and daily during the hospitalization. Presence of nasogastric tube, flatus, bowel sounds, bowel movements, effective cough, and complications were recorded on a daily basis. Other data such as length of hospital stay, smoking history, and previous lung disease also were recorded.

Although this study currently is in the early stages, data from the first cases suggest that spirometry can measure accurately upper abdominal incision pain and that TENS appears to have some benefits over conventional therapies.

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# The Absence Of Extrajunctional Cholinesterase Activity And Terminal Motor Nerve Sprouting In Chronic Local Tetanus

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S. M. CHOU, M. D.

A paper by Duchen and Tonge[1] reports axonal sprouting associated with extrajunctional cholinesterase activity in the soleus muscles of mice seven days after a single, non-lethal IM injection of tetanus toxin sufficient to cause local tetanus of the hind limb lasting approximately four weeks. A new method for studying and quantifying terminal sprouting and extrajunctional cholinesterase activity was described by Pestronk and Drachman.[2]

The objective in the research reported here was to quantify the results of Duchen and Tonge using the methods of Pestronk and Drachman.

Eight rats weighing 200-250 g were injected in the soleus of the right hind limb with 50 ng of tetanus toxin. Muscle was taken at various intervals between three and 28 days, and serial, longitudinal cryosections 50 um in thickness were cut and stained. Endplates were measured and terminal branch points counted. No extrajunctional cholinesterase activity or terminal motor nerve sprouting could be detected for any of the survival times.

In conclusion, in contrast to the data obtained by Duchen and Tonge from mice, in the present study with rats chronic local tetanus does not induce extrajunctional cholinesterase activity or terminal motor nerve sprouting in the soleus muscle.

1. *J Physiol* 228:157, 1973.
2. *Muscle & Nerve* 1:70, 1978.

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# Regulation Of Cell Growth By Phosphorylation Of DNA-Binding Proteins

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SINCE unregulated cell growth is the primary element responsible for the initiation of a neoplastic disease process, current cancer research has focused on uncovering the normal controls on growth operating in the cell. DNA-binding proteins are known to function in intracellular growth regulation. My objective was to show whether these proteins are themselves regulated by phosphorylation — a common means of intracellular control. Specifically, this experiment was designed to find a possible correlation between cell growth cycle phase and $^{32}$P-label uptake by DNA-binding proteins in a tissue culture system of non-neoplastic cells.

Two sets of BHK (baby hamster kidney) cultures were examined: an exponentially-growing set of cells, maintained in 10 per cent calf serum, plus a second group maintained in growth-arrested ($G_0$) phase with 0.1 per cent calf serum. Both groups of cells were incubated

four hours in the presence of $^{32}P$-labelled media (10 mCi/ml, inorganic phosphate). The cells were then harvested, homogenized, and the DNA-binding proteins were collected on both single- and double-stranded DNA-cellulose columns. Proteins were eluted from the columns using high-salt (2.0 M NaCl) solution and further purified and separated via TCA-precipitation and SDS-gel electrophoresis. Autoradiography — exposure of x-ray film to the labeled proteins embedded in the dried gel — was used to determine the uptake of $^{32}P$ by each of the protein bands. The approximate molecular weight of each labeled protein was computed by comparison with simultaneously-run standards.

My results show that as the cells move from the $G_0$ into the exponential growth phase, a high-molecular-weight (96-120,000) protein is *de*-phosphorylated. At the same time, a low-molecular-weight protein (15-16,000) *becomes* phosphorylated. This second protein bound preferentially to *double*-stranded DNA, while the high-molecular-weight protein bound mostly to *single*-stranded DNA.

The data suggest that a phosphorylation-based mechanism of growth cycle control is indeed operating in this culture system. One possible explanation of our findings is as follows: the high-molecular-weight protein, since it binds to single-stranded DNA, plays an active role in *promoting* replication. It is therefore phosphorylated, and inhibited, during the growth-arrested phase. The low-molecular-weight protein, on the other hand, might *inhibit* replication by stabilizing the DNA in its double-stranded form. It is, therefore, dephosphorylated (and active) when the cells are *not* dividing, and phosphorylated during active growth. Presumably, further studies using *tumor* rather than normal cell cultures may pinpoint an irregularity in this regulatory system as one molecular basis of cancer.

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# Effects Of Dipyridamole On Adenosine Metabolism In Dog Whole Blood

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Adenosine (ADO), a vasodilating metabolite, is deaminated to inosine (INO) by adenosine deaminase which is located in tissue and blood. The purpose of this research was to quantitate the effects of dipyridamole (an inhibitor of cellular ADO uptake) on exogenous and endogenous ADO metabolism in dog whole blood.

Dog whole blood (heparinized) was incubated at 37°C. Exogenous ADO (9 $\mu$M or 100 $\mu$M) was added. Samples were withdrawn at one, five, 10, 20 and 30 min., extracted with perchloric acid, neutralized, and assayed for ADO and INO by high-pressure liquid chromatography. Four vials of blood were used in each experiment. Two were spiked with exogenous ADO — one with dipyridamole (DIPY) and one without; and two contained only blood — one with DIPY and one without.

The disappearance of exogenous ADO followed first-order kinetics. The half-life ($t^{1/2}$) for ADO disappearance (9 $\mu$M) without DIPY was 3.4 $\pm$ 0.3 (SE) min. With DIPY concentrations of $10^{-7}$ to $10^{-4}$M, the ADO $t^{1/2}$ increased 3 to 5-fold, while $10^{-8}$M DIPY did not significantly change the ADO $t^{1/2}$. The $t^{1/2}$ for 100 $\mu$M ADO without DIPY was 6.9 $\pm$ 1.1 min. The ADO disappearance (9 $\mu$M) was accompanied by an increase in inosine from 0.52 $\pm$ 0.10 to 2.90 $\pm$ 0.23 $\mu$M over the 30-min. period.

In blood with no exogenous ADO or DIPY, endogenous ADO concentrations increased from 0.37 $\pm$ 0.21 to 1.06 $\pm$ 0.20 $\mu$M over a 30-min. period. In this same group (blood only), INO concentrations exhibited a linear increase from 0.28 $\pm$ 0.05 to 1.71 $\pm$ 0.19 $\mu$M.

Therefore, the disappearance of ADO in dog whole blood is inhibited by DIPY concentrations of $10^{-7}$ to $10^{-4}$M. Also, this study has demonstrated that adenosine and inosine are produced by dog blood in vitro.

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# Transcutaneous Oxygen Monitoring For Assessment Of Umbilical Artery Catheter Clots

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MARTHA MULLETT, M. D.
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It has been demonstrated, by Neal *et al.*, that greater than 90 per cent of neonates with indwelling umbilical artery catheters show development of catheter-associated thrombi in the aorta. Use of the Roche, Model 630 Transcutaneous Oxygen Monitor was explored for application in the detection of these blood clots. The transcutaneous $pO_2$ ($tcpO_2$) measurement is proportional to the capillary flow to the skin. Theoretically, decreased flow will be recorded as lowered transcutaneous $pO_2$ readings. Areas of decreased perfusion due to clots, i.e., the lower extremities, should show lower transcutaneous $pO_2$ readings than areas of normal perfusion, i.e., the chest. Lowering of transcutaneous $pO_2$ readings should be proportional to the extent of umbilical artery catheter clot.

Twenty-three neonates participated in the study. Eighteen subjects had indwelling umbilical artery lines, and five had no catheters in place. Mean gestational age was 32 weeks. Mean weight was 2,229 grams. Subjects were studied serially, with the last determination 24 hours after the line was removed. A single determination consisted of sequential transcutaneous $pO_2$ measurements of chest, left leg and right leg. Each determination was examined independently.

On one occasion, a sharp drop in transcutaneous $pO_2$ reading to one of the legs was seen on a patient approximately 48 hours before the umbilical artery line clotted. However, on the whole, such site differences were not statistically significant. These differences may have been the result of the $tcpO_2/pAO_2$ error inherent in the machine.

# Temperature Modulation Of Macrophage Functions

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Chronic infections by such organisms as *Mycobacterium marinum* and *Sporothrix schenckii* classically involve the skin and subcutaneous tissues of the distal limbs. The skin temperature of the distal limbs is usually 32°C or less. This temperature may favor organisms that thrive preferentially at these cooler temperatures. However, an altered cell-mediated immunity at temperatures below visceral temperature also may be an important factor in predisposing the host to such infections. The present study, therefore, was designed to examine whether the biological functions of the macrophages were altered by temperature variation.

Peritoneal macrophages were harvested from guinea pigs after oil induction. The biological functions of these cells were assessed at 25°, 28°, 33° and 39° C and were compared with those at 37°C (as control). The results indicated that bactericidal activities of the macrophages decreased significantly after 90 and 180 minutes of incubation at all test temperatures. Phagocytic uptake of the opsonized bacterial cells also was affected profoundly in monolayer cultures under these conditions.

The extracellular attachment of the bacteria to the phagocytes was not inhibited. Acid phosphatase, but not $\beta$-N-acetyl glucosaminidase, activities decreased significantly with variation in incubating temperatures. Nylon wool adherence of macrophages showed consistent reduction under experimental conditions; however, the differences from the control value were not significant. Finally, macrophage migratory capacity in Mackaness chambers was remarkably reduced, and this decrease was most pronounced at 25°C (90 per cent).

These data may indicate that the biological functions of macrophages may not operate optimally at temperatures other than 37°C. It is suggested that this compromised host function may play an important role in predisposing the skin extremities to infectious agents that thrive better at lower temperatures.

# Transcutaneous $PO^2$ Monitoring As An Index Of Peripheral Perfusion Following Cardiac Surgery

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ACCURATE transcutaneous oxygen tension ($TcPO_2$) is dependent upon normal peripheral perfusion. The difference between intra-arterial $PO_2$ and $TcPO_2$ may reflect quantitatively suboptimal perfusion in children following cardiac surgery. To test this hypothesis, 14 children (ages 2 months to 16 years) had serial simultaneous measurement of $PAO_2$ and $TcPO_2$ postoperatively.

Three patients had no difference between $PAO_2$ and $TcPO_2$ following simple palliative procedures, and peripheral perfusion was normal. However, the 11 children repaired under cardiopulmonary bypass exhibited an initial wide discrepancy between $PAO_2$ and $TcPO_2$ (m=42.6 Torr) which correlated with suboptimal peripheral perfusion, assessed by a grading system utilizing capillary filling, skin temperature and color. As perfusion returned to normal, usually within eight hours after surgery, $PAO_2 - TcPO_2$ decreased significantly (m=7.8 Torr), $p<.01$. A greater than 50 per-cent decrease in $PAO_2 - TcPO_2$ occurred in 10 of 11 patients (m=81.7 per cent). Changes in $PAO_2 - TcPO_2$ did not correlate with central arterial and venous pressures, skin and rectal temperatures or ventilator therapy. Trunk $TcPO_2$ was approximately 10 Torr higher than extremity $TcPO_2$, and fluctuated less markedly with manipulation such as suctioning.

This study demonstrates that in 13 of 14 children studied the difference between $PAO_2$ and $TcPO_2$ accurately reflected peripheral perfusion postoperatively following cardiac surgery.

# Characterization Of Cytochalasin B Binding To Rat Liver Parenchymal Cells In Tissue Culture

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THE essential role of glucose metabolism in meeting the energy requirements of a cell long has been recognized in both normal and neoplastic issue. However, before the glucose molecule can be oxidized, it first must be transported into the cell. The liver is the primary organ of glucose homeostasis, and in this study we have attempted to characterize the hexose transport system of the hepatocyte. Cytochalasin B is a potent inhibitor of hexose transport in many types of eucaryotic cells, and so its binding and resulting effect on glucose transport were studied in this system.

Cells were isolated from adult, male rats by perfusing the liver *in situ* with collagenase, and hepatocytes were separated from the other cell types by differential centrifugation. The cells then were established in primary tissue culture. The binding of [$^3$H]-cytochalasin B, and the transport of 3-0-methyl-D-glucose [$^{14}$C], a non-metabolized analogue of glucose, into cells were investigated in monolayer culture, followed by digestion of the cells and scintillation counting of radioactivity retained.

Binding of cytochalasin B to liver cells was rapid and reversible. Analysis of the kinetics by Scatchard plots revealed that binding was biphasic, with the parenchymal cell being extremely rich in high-affinity binding sites. These high-affinity sites, thought to be the glucose transport carrier, exhibited a $K_D$ of $2.86 \times 10^{-7}$M, while the low-affinity site had a $K_D$ of $1.13 \times 10^{-5}$M. The mean maximum binding capacity of the high-affinity sites, roughly reflecting the number of glucose transport carriers, revealed $2.0 \times 10^8$ sites/cell, almost a thousand fold greater than any other cells so far examined.

To substantiate that cytochalasin B does bind to the hexose transport location, it was found that cytochalasin B ($10^{-5}$M) drastically inhibited

sugar transport, while cytochalasin E, which does not inhibit transport, was competitive with cytochalasin B only at the low-affinity sites. It also was found that D-glucose ($10^{-5}$M) did not displace cytochalasin B. Therefore, a model can be postulated whereby cytochalasin B inhibition of hexose transport occurs at the high-affinity site, but the inhibition is non-competitive in nature.

In conclusion, it appears that the liver parenchymal cell may represent an unusually rich source of the glucose transport system which may be useful in the isolation of this important membrane carrier.

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# Histoenzymatic Study Of Steroid Synthesis In The Rat Preovulatory Follicle Under Various Experimental Conditions

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THE $\Delta^5$-3$\beta$-hydroxysteroid dehydrogenase enzyme system catalyzes obligative steps in the formation of progestins, estrogens and androgens. The *in situ* localization of this system may provide important clues as to the steroid synthesis by individual ovarian compartments. The hypothesis is presented that there is a relationship between altered hormonal milieu and asynchrony of preovulatory events which may be manifested by a decreased capacity for production of a normal ovum. The aged ovum has been associated repeatedly with decreased reproductive capacity.

Experimental groups of at least five animals each were killed at 12:00, 17:00 and 20:00 hours of proestrus, and consisted of 200-275 g four- or five-day cycling rats, aged (>14 months) four-day cycling rats, young rats in which ovulation was delayed 48 hours with pentobarbital sodium, and aged rats with a 48-hour spontaneous delay of ovulation. Intensity of the enzymatic reaction was graded + to ++++.

There was no difference in the reactivities of young four- and five-day cycling rats. In most aged rats with regular cycles the reactivity of most preovulatory follicles was similar to young rats, but there was a slight decrease in total ovarian reactivity. During delayed ovulation in young rats the granulosa layer thinned and became uniformly reactive as the preovulatory follicle continued to enlarge. The reactive theca interna was organized into nests with their greatest frequency adjacent to the ovarian surface. This layer was highly reactive in the preovulatory period of regularly cycling rats, but became less reactive during delayed ovulation. There was a vast heterogeneity of reactivity patterns in the aged rats, suggesting a possible deleterious alteration in hormone production.

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# Purification And Immunological Evaluation Of A Lung Tumor-Associated Antigen

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PETER E. MAXIM, Ph.D.

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THE objective of this study was to assess the propensity of using a membrane-bound lung tumor antigen in the development of a laboratory screening test for the parent squamous cell lung carcinoma. The antigen, having been obtained by detergent extraction methods from surgical specimens and a pleural effusion, was purified by ion exchange and gel filtration chromatography. The fractions were concentrated, and the antigenic reactivity was demonstrated by double diffusion technics. The fractions received further treatment and were injected into goats and rabbits.

Antisera previously obtained by these methods were purified by affinity chromatography and heat treated to inactivate nonspecific reactive components. The antisera were incubated with

slide preparations of bronchial washes, sputum samples and pleural effusions. The rabbit antisera-slide preparations were exposed to a second fluorescent antiserum specific to the rabbit immunoglobulins, and the slides were observed for fluorescent cells under a U-V microscope.

Of questionable malignancies or malignancies confirmed by biopsy, 64.5 per cent were positive, 29 per cent were weakly positive, and 6.5 per cent were negative for the antigen by indirect immunofluorescence. In the normal and benign controls there were fewer positive and weakly positive preparations. These results indicated that antisera could be used to detect the tumor antigen; however, false positives were strongly suggested in normal and benign controls. Additional purification of the antigen and antisera, as well as determinations derived with a larger number of biopsy-confirmed cases, would be required to substantiate using this model for a lung cancer screening test.

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# Human T Cell Alloantigens

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THIS work, accomplished in the WVU Tissue Typing Laboratory, demonstrates the probable existence of an alloantigenic marker for a subpopulation of human T cells. Existence of such a system is strongly suggested by the T cell alloantigenic systems of the mouse. Mouse antigen systems previously have been shown to bear strong homology to other human antigen systems.

Detection of as yet such an undefined alloantigenic system for human T cells could greatly increase our ability to dissect the functional subclasses of T cells directly involved in control of the immune response. At present, such studies rely heavily on heterologous anti-T cell sera that require meticulous purification before use. The demonstration of an antibody in sera specifically reactive to T cells or fractions of T cell populations would support the existence of such an alloantigenic system.

Thirty sera from multiparous human females and human transfusion recipients were screened against our laboratory's frozen lymphocyte typing panel using standard tissue-typing techniques for presence of cytotoxic antibody. Ten sera for further study were selected based upon strength and frequency of reaction to the typing panel. These sera were absorbed with pooled platelets to remove antibody to all HLA specificities except the B cell specific DR antigens. Seven cells for further study were chosen based upon frequency of reaction to these selected sera. Several types of cell preparations were used in testing: peripheral lymphocytes, T & B cell enriched populations, and lectin-activated or mixed lymphocyte culture (MLC)-activated T cells.

Initial results obtained included identification of probable anti-DR activity in two sera and the demonstration of probable DR-like antigens on lectin (PHA)-stimulated lymphocytes.

Of central importance here, cytotoxicity to "resting" nonactivated T cells was demonstrated for one serum against cells from one donor. This activity strongly suggests the presence of a specific T cell antigenic marker not previously defined. This conclusion is supported by cytotoxic activity by this same serum against both the MLC- and lectin (PHA)-activated cells. In addition, B cells were unreactive with this antiserum. The strength of the reaction, 20-30 per cent killing, suggests further that this marker is present only on a subpopulation of T cells.

The identification of the subpopulation(s) that possesses the marker must await functional studies, which will be the object of our future work.

# *The President's Page*

*Guest Author*
*Ruth (Mrs. Gary G.) Gilbert, President*
*Auxiliary to the*
*West Virginia State Medical Association*

## DOCTOR, ARE YOU IN SHAPE?

Our theme in the Auxiliary this year is "Our Family—Keep It Healthy." This fits in with the AMA Auxiliary health project, "Shape Up for Life." Just as the holiday season is beginning, with all the good things to eat and parties to attend, it is difficult to speak about watching your waistline. But many Auxiliary members (myself included) are working hard to improve our health by losing those extra pounds we have been carrying around that take years from our life and looks. We want to have that extra spark of energy at the end of the day to share with you.

Our programs in the counties are geared to encourage everyone to take better care of their families' health. But what about *you*, our hard-working spouse? When was the last time you took a good, long look at yourself in the mirror? Did you like what you saw? Would you let your patients take such poor care of themselves? I think not!

So, no matter if the office hours start later than usual a couple of mornings a week, do yourself and your family a favor, and jog, exercise at the YMCA, ride a bike, or do any exercise suited to your age. Most important of all, *stop smoking!*

That phrase, "Physician, heal thyself," may not be so easy if you have neglected the basics for too long. We, your family, love you dearly and want you to take as good care of yourself as you do your patients. If you are like I am, your spouse and family are the center of your world. Perhaps this is truer for a woman than a man, but whatever the reason, promoting better health in the medical families of our state is the aim of the Auxiliary this year.

Home is truly where the heart is at this time of year. May your family be blessed with love, health, and happiness in the coming year.

Ruth Gilbert

The West Virginia Medical Journal

# Editorials

The Publication Committee is not responsible for the authenticity of opinion or statements made by authors or in communications submitted to this Journal for publication. The author shall be held entirely responsible.

**MINORITY VIEWS**

At a recent conference of state journal editors, several invited speakers protested that minority views within Medicine are rarely given the opportunity to be heard. The implication was made that Medicine is led by some sort of a centrist plot and that deviant views are systematically quashed.

Little in the presentation of the protestors or the peculiarities for which they are otherwise known added much to reinforce their plea. Their cause, it seemed apparent, was medical consumerism. It is very fashionable these days in many circles to trumpet the democratic ideals of Naderite consumerism.

The purpose, alas, of this essay is not to deal with imbecilities of consumerism, but rather to deal with the charge that minority views can find no expression in medical affairs. Those who seriously hold such an opinion reveal one very damning fact about themselves: they have never been to a county medical society meeting, let alone a state association or a national AMA meeting.

Minority views are undeniably, sometimes relentlessly and always vigorously, expressed at any medical meeting. Some might describe views heard at medical meetings as idiosyncratic, or even unique. We have no sympathy for someone sitting in a corner, muttering in his beard about the injustice of the profession, or of the world. It's an unusual doctor who requires encouragement to give his opinion on anything.

Medical meetings, in truth, are the epitome of democracy. All who attend can and sometimes, it seems, do make speeches on any subject anyone has the urge to bring up. In that sense, medical affairs can be maddeningly democratic. No one could possibly go away with the feeling that he has been muzzled.

We cannot speak for all medical journals, but we rather expect that in regard to the submission and publication of minority or controversial views, our experience is similar to theirs: papers expressing such views are simply not submitted to medical journals. And why should they be? Would they get the same applause or achieve the same notoriety in a medical journal as they would if published by Americans for Democratic Action; or the American Civil Liberties Union, or any number of other organizations of similar ilk?

In publications by groups such as these, minority views in Medicine have the happy facility of becoming the overwhelming majority views of the readers. It is much more gratifying to hear those expressions of love and appreciation than it is to hear the hooting, the boos and bronx cheers that might await the author in another forum. Who can blame them?

Still, it grieves us to be denied the opportunity to publish something that might cause a stir. We like to know these pages are read. We know we have your attention when you write us.

We think we know the majority views in Medicine. We have no fear of publishing any contrary views. We have every confidence that our readers will quickly establish what might be and what might not be the majority view on any topic.

We herewith solicit expressions of anything considered controversial or reflecting a minority view on any subject of interest to physicians. We will publish anything within the bounds of good taste and acceptable English usage. How about Consumerism in Medicine? Anyone for National Health Insurance? Have anything to say about health manpower problems? CME? Care to say something nice about HSA?

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**SECTIONS, SOCIETIES**

During the last few years, the House of Delegates has done a substantial job of amending the Medical Association's Constitution and By-Laws. Some of the amendments have been of a technical nature. Most, however, have produced substantive change—such as those opening Association membership to medical students—and they will require time for full implementation.

One of the substantive changes came in 1979.

It added to the By-Laws a new chapter dealing with objectives, membership requirements and continuing medical education responsibilities of specialty sections and societies organized under broad Constitutional language.

Before 1979, the By-Laws were silent in this area. The Constitution has stipulated, and still does, simply that "The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections, and for the organization of such societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component societies."

The House has carried out its basic responsibility, with recent creation of sections of dermatology and emergency medicine as examples. But until the 1979 By-Laws amendment, there was no "meat," in the form of specific guidelines and requirements for section/society activity, on the Constitution "bone."

Some of the scientific sections and societies are well organized. They maintain a regular pattern of electing officers; communicating with their members, and holding annual and even semi-annual scientific programs. But this is not the overall situation, by considerable.

The By-Laws say that House-established specialty groups are "(a) to form closer professional relationships among physicians practicing in particular specialty areas; and among medical residents and students; and (b) to foster among physician members of particular specialties. and among residents and students, educational and other activities directed toward better patient care."

Section/society membership shall be predicated, along with pertinent general Constitutional requirements, on at least one of the following: a physician devoting a major portion of his practice to the specialty involved; appropriate board certification; or ability to meet specific membership requirements a section/society might itself adopt. Each section/society must have a mechanism for electing its officers, and must make certain a current roster of officers is on file with the State Medical Association's Executive Secretary.

Perhaps most important, each section/society *shall* set up and maintain a continuing medical education program. This program shall be developed on such bases as size and geographical location of membership; objectives of particular significance to the section/society; and how the program "*best can be directed toward better patient care.*"

In view of current pressures related to Joint Commission on Accreditation of Hospitals and professional standards review requirements—and the major quality of care element in a complex professional liability (malpractice) insurance dilemma—these By-Laws provisions take on increased significance.

Sections and societies must take them seriously, and move steadily and effectively toward getting their individual houses in order where this has not, or is not now being, done. Residents and medical students also need to get their sections established, in line with other By-Laws provisions, and the Association's State Office will be attempting to provide some help in this area. That office also stands ready at all times to assist sections/societies. But the initiative for solid, positive action needs to come from those professional groups themselves.

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**A REAL BARGAIN**

It's "big bargain" time again for West Virginia's physicians. For just $40. you can obtain some of the best continuing medical education benefits around. That's the registration fee for the 14th Mid-Winter Clinical Conference scheduled for January 23-25 in Charleston.

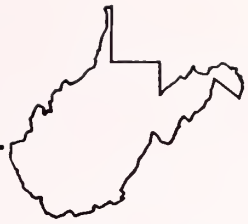
The Conference again will offer some 13 hours of courses carrying Category I credit toward the American Medical Association Physician's Recognition Award, and Prescribed Credit under the American Academy of Family Physicians CME program.

Details of the program are being unfolded monthly in the news section of *The Journal.* By now, State Medical Association members and others have received—or soon will—a special mailing with a registration form.

It's become habit to say, each year, just how far the mid-winter program has come since its beginnings as a Sunday afternoon chest conference in a small room at the old Memorial Hospital in Charleston. But the programs HAS come a long way, with well deserved billing as the top CME offering by the State Medical Association each year.

The West Virginia University and Marshall University Schools of Medicine again will join the Association in sponsorship roles this year. The program once again has been shaped for that physician. out in the state, who can take some time beginning Friday afternoon and running through Sunday morning to absorb practical information that he can take back to his office and his practice the following Monday morning.

# GENERAL NEWS



## Microsurgery Among Mid-Winter Conference Subjects

Dr. David A. Kappel, Wheeling plastic surgeon, will speak during the 14th Mid-Winter Clinical Conference, it was announced by the Program Committee.

The annual continuing education event will be held January 23-25 in Charleston at the Holiday Inn Charleston House. Sponsors are the State Medical Association and the Marshall University and West Virginia University Schools of Medicine.

Doctor Kappel will speak on "Overview of Microsurgery" during the opening session beginning at 2 P. M. on Friday, January 23.

There also will be two speakers on fiberoptics during the opening session, with papers on ERCP and, as announced previously, "Indications for Colonoscopy." The latter will be presented by James W. Manier, M. D., of Morgantown, WVU Professor of Medicine and Chief, Section of Gastroenterology.

David A. Kappel, M.D.

Carl J. Malanga, Ph.D.

Carol J. Miller

John F. Otto, M.D.

Scientific sessions also are scheduled for Saturday afternoon and Sunday morning, with the conference concluding at noon on Sunday.

The program meets the criteria for 13 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association, and also is acceptable for 13 Prescribed hours by the American Academy of Family Physicians.

The location of the conference general sessions at the Charleston House has been changed from the Wertz Ballroom, the site in recent years, to the newer and larger Hutchinson Ballroom, the Program Committee announced.

### Teaching Assignments

Doctor Kappel is a WVU Clinical Associate Professor of Surgery, and has teaching assignments with medical students, house staff, nurses and emergency medical technicians at WVU Wheeling Division-Ohio Valley Medical Center, Inc.

Certified by the American Board of Plastic Surgery, his research interest has been the effect of inhalation anesthetics on arteriovenous shunts in random flaps in the pig.

A native of Long Beach, California, Doctor Kappel was graduated from WVU and also received his M. D. degree, in 1969, from WVU. He interned at Swedish Hospital Memorial Center in Seattle, Washington, and completed residencies at the Kansas University Medical Center in Kansas City, Kansas.

A physicians' session at 8 P. M. Friday will be conducted by the West Virginia Medical Institute, Inc., concurrently with a public session on "What's New in Allergy." Dr. L. Blair Thrush, M. D., of Morgantown, WVU Assistant Professor and Chief, Section on Allergy and Clinical Immunology, will be the principal speaker for the latter session.

### 'Drug Interactions'

Carl J. Malanga, Ph.D., of Morgantown, Professor of Biopharmacy, School of Pharmacy, WVU, will talk on "Drug Interactions" during the Saturday morning session.

Two papers will be given Saturday morning under the general topic of "Antibiotic Update." Patrick Robinson, M. D., Department of Internal Medicine, WVU Charleston Division, will discuss "Aminoglycosides," and William C. Graham, M. D., MU Assistant Professor of Medicine, Section of Infectious Diseases, "Cephalosporins." Doctor Thrush also will talk Saturday morning on "Drug Allergy."

Speaking during the Saturday afternoon session on "Current Controversies In Medicine" will be John C. Linton, Ph.D., Associate Professor and Chief Psychologist, Department of Behavioral Medicine and Psychiatry, WVU Charleston Division, who will take the behavioral modification approach in the "Treatment of Obesity."

Mohammed M. Boustany, M. D., Clinical Assistant Professor of Surgery, WVU Charleston Division, will discuss surgical treatment of obesity.

In a discussion of "TIA: Is Surgery Indicated?," Arthur L. Poffenbarger, M. D., of Charleston, WVU Clinical Professor of Neurology, will take the "con" position, while G. Robert Nurgent, M. D., of Morgantown, WVU Professor of Surgery and Chairman, Department of Neurosurgery, will take the "pro" position.

### Panel Discussion

A cash bar and hors d'oeuvres are scheduled Saturday evening from 6:30 to 7:30.

"What You May Be Doing Next Year ! ! !," a panel discussion on individual practice associations (IPAs) and health maintenance organizations (HMOs), will constitute the concluding Sunday morning session.

The six panelists will be Jacob J. Spies of Boston, Director of Health Systems, Center for Industry and Health Care, Boston University; James G. Stumpfel of Wheeling, Executive Director, The Health Plan of the Upper Ohio Valley, Inc. (HealthPlan), an IPA; Mrs. Carol J. Miller of Beckley, Executive Director, Healthwise, also an IPA;

John F. Otto, M. D., Huntington, member of the Board of Directors and 1979-80 President, Valley Health Foundation, HMO Study; Frederick M. Cooley, M. D., Charleston, Medical Advisor for an HMO study in Charleston, and Charles G. Brown, J. D., of Charleston, Deputy Attorney General and Director of the Antitrust Division, West Virginia Attorney General's Office.

Doctor Malanga, a native of New York City, has been a member of the WVU pharmacy faculty since 1970. He was recipient of the WVU Outstanding Teacher Award in 1974, 1977 and 1979.

Mrs. Miller, who holds a B. S. degree in nursing from Alderson-Broaddus College, has held her present position with Healthwise since 1977. She has served as a pediatric nurse in Clarksburg, a nursing instructor in Clarksburg and Buckhannon, and in administrative positions with other health care groups in West Virginia and Pittsburgh.

### Huntington Internist

Doctor Otto is a partner in the Huntington Internal Medicine Group, Inc., and is MU Clinical Assistant Professor of Medicine. He was Chairman of the West Virginia State Health Coordinating Council from 1978 to 1980, and currently is Chairman of Region II, Health Advisory Committee of West Virginia Health Systems Agency.

A native of New York City, Doctor Otto was graduated from Harvard University and received his M. D. degree in 1948 from the University of Cincinnati.

A registration fee of $40 will be charged all registrants except nurses, medical students, interns and residents. For advance registration, make checks payable to West Virginia State Medical Association, and mail to the Association at P. O. Box 1031, Charleston 25324.

The third annual "Frostbite Frolic" 5,000- and 10,000-meter runs will be held in Charleston Saturday, January 24, in conjunction with the conference. The runs will begin at 8:30 A. M. at the WVU Medical Education Building. For additional information and registration forms, contact Dr. Alfred K. Pfister, Kanawha Valley Road Runners Club, 794 Echo Road, South Charleston 25303.

The remaining speakers, and final conference details, will appear in the January issue of *The Journal.*

## Auxiliary Review Includes Fayette Project

Mrs. Joe N. (Astri) Jarrett of Oak Hill and the Fayette County Auxiliary are included in a 10-year review of the activities of the American Medical Association Auxiliary in the 70s.

The review, an article entitled, "Decade of Events," appears in the November issue of the Auxiliary's *Facets*.

The Fayette County project which was described, "Operation Backyard," originally was planned as lecture-cooking demonstration classes to help food stamp recipients in nearby Minden prepare palatable, low-cost, nutritious meals, but grew far more encompassing as the Fayette County Auxiliary conducted the pilot program.

Astri Jarrett conceived and launched the program after being challenged by her teenaged son.

The county health department and the West Virginia University Cooperative Extension Service helped as the project grew, "but local churches proved to be the saving point," the article stated. "Most had kitchen facilities, and attendance grew when the program moved to a more familiar, comfortable place than the first site — a local power company kitchen."

Mrs. Jarrett was 1969-70 President of the Auxiliary to the State Medical Association.

Husband Joe is a family physician.

## Contacts From Handicapped Doctors Requested

A physicially-handicapped physician in St. Paul, Minnesota, is interested in contacting other handicapped physicians in order to obtain some approximation of the size and characteristics of this population in the United States and Canada.

All physicians, active or inactive, with any type of physical handicap are asked to contact Frank C. Zondlo, M. D., St. Paul-Ramsey Medical Education and Research Foundation, 640 Jackson Street, St. Paul, Minnesota 55101.

The Foundation is involved in a project directed towards serving the needs of handicapped physicians. The goal of this project is to form a voluntary group of handicapped physicians who will provide information and referral services as well as support and advocacy for physicians who become handicapped.

## Medical Scholarship Awarded To Wellsburg Resident

John A. Leon of Wellsburg, a 1980 graduate of Notre Dame, has been awarded one of the State Medical Association's four medical school scholarships this year.

Leon, a varsity football player for the Irish—he was a starting offensive guard on the 1979 team—is the son of Mr. and Mrs. William J. Leon of Wellsburg. He received an A.B. degree in psychology from Notre Dame.

Leon was awarded the $1,500-a-year, four-year scholarship when one of the four selectees of the Medical Association's Committee on Medical Scholarships was unable to accept. He was the Committee's selection as first alternate. Leon is enrolled in the West Virginia University School of Medicine.

# *Review A Book*

The following books have been received by the Headquarters Office of the State Medical Association. Medical readers interested in reviewing any of these volumes should address their requests to Editor, *The West Virginia Medical Journal*, Post Office Box 1031, Charleston 25324. We shall be happy to send the books to you, and you may keep them for your personal libraries after submitting to *The Journal* a review for publication.

*Basic Histology, 3rd Edition*, by Luis C. Junqueira, M. D.; and Jose Carneiro, M. D. 504 pages. Price $15.50. Lange Medical Publications, Los Altos, California 94022. 1980.

*Review of Medical Pharmacology, 7th Edition*, by Frederick H. Meyers, M. D.; Ernest Jawetz, M. D., Ph.D.; and Alan Goldfien, M. D. 747 pages. Price $17.50. Lange Medical Publications, Los Altos, California 94022. 1980.

*The Human Patient*, by Naomi Remen, M. D. 238 pages. Price $10.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10017. 1980.

*Every Woman's Health: The Complete Guide to Body & Mind* (by 17 women doctors), Edited by D. S. Thompson, M. D. Illustrated. 776 pages. Price $19.95. Doubleday & Company, Inc., 245 Park Avenue, New York, New York 10017. 1980.

## AMA Winter Scientific Meeting Planned In January

Postgraduate courses, lectures and update workshops will be featured at the American Medical Association Winter Scientific Meeting January 24-26 in Atlanta (Atlanta Hilton Hotel).

The complete program for the meeting was published in the October 24/31 Journal of the American Medical Association.

Genetic engineering and brain hormones will be among the special topics presented by distinguished lecturers for the assembly. A special program will be offered on the physician's role in nuclear power and possible nuclear accidents.

The AMA's annual Conference on Sports Medicine will be held in conjunction with the scientific meeting on January 24. The AMA Auxiliary will present special programs for physicians' spouses during the meeting.

Physicians will participate in lecture sessions and study courses on a wide variety of medical topics at the convention, said Richard M. Bergland, M. D., Chairman of the AMA's Council on Continuing Physician Education.

### Golden Age?

John T. Potts, Jr., M. D., Professor of Medicine and Chief of the Endocrine Unit, Harvard Medical School and Massachusetts General Hospital, Boston, will present the distinguished lecture on "Does the Dawn of Genetic Engineering Herald a Golden Age in Medicine?"

With recent public reports that gene splicing is approaching the commercial stage in American laboratories, physicians foresee a wide range of useful products from the ability to transplant a gene from one organism to another. Doctor Potts will discuss possible applications of gene splicing and genetic engineering to the everyday practice of medicine.

Another research field with great hope for the medical future will be aired in a distinguished lecture by Gavril W. Pasternak, M.D., Ph.D., neurologist at Cornell University Medical College and Memorial Sloan-Kettering Cancer Center, New York City.

"Endorphins and Beyond: The Future of Brain Hormones in Clinical Medicine," will be Doctor Pasternak's topic.

Further information on the convention is available from the Department of Scientific Assembly, AMA, 535 N. Dearborn St., Chicago, IL 60610.

## State EENT Group Sets Spring Meeting

Intraocular lens and refractive keratoplasty will be among the subjects discussed at the 1981 National Spring Meeting of the West Virginia Academy of Ophthalmology and Otolarynology.

The meeting will be held next April 26-29 at the Greenbrier in White Sulphur Springs.

There also will be papers on retinal detachment, vitrectomy, ultrasound, radiology, and facial, plastic and reconstructive surgery.

Ophthalmology speakers will be Drs. Steven T. Charles, Miles H. Friedlander, Miles A. Galin, Richard P. Kratz, Randall J. Olson and George W. Weinstein; otolaryngology: Drs. Jack Anderson, Kenneth Dolan, Robert Kohut and Mansfield Smith.

The program will be approved for credit in Category 1 of the Physician's Recognition Award of the American Medical Association.

The registration fee will be $175. Checks should be made payable to the Academy and sent to J. Elliott Blaydes, M. D., Frederick and Woodland, Bluefield 24701.

Room reservations should be made directly with the hotel.

## Medical Women Plan Meeting April 4

The effect of consumerism on medicine will be the subject of a meeting of West Virginia Branch No. 41 of The American Medical Woman's Association next April 4 in Huntington.

The Marshall University Student Center will be the meeting site.

The group also met in October in Clarksburg, with Dr. Patricia W. Williams of Morgantown as the speaker. Officers for the years 1981-83 were elected at that meeting. They are: Drs. Florence K. Hoback, Huntington, President; Patricia Williams, President Elect; Barbara Tenney, Morgantown, Secretary, and Zinnia Giron-Bacol, Romney, Treasurer.

## Doctor Ketchum Reelected To House of Delegates

Dr. Dorsey Ketchum, Huntington Democrat, won election on November 4 to his third two-year term in the West Virginia House of Delegates from the 11th Delegate Distrct.

Dr. Isaiah A. Wiles, a Morgantown Republican, was unsuccessful in his first general election race for the House in the 27th District.

## Sports Medicine Conference January In Atlanta

Topics dealing with "Facial and Oral Related Injuries in Sports," "Nutrition Relating to the Athlete," and "Knee Pain in the Athlete" will be addressed in Atlanta, January 24, at the 22nd National Conference on the Medical Aspects of Sports.

Sponsored by the American Medical Association, the day-long conference, to be held at the Atlanta Hilton Hotel, will feature former premier major league relief pitcher, Mike Marshall.

In the general session dealing with "Facial and Oral Related Injuries to Sports," Gary L. Racey, D.D.S., of Columbus, Ohio, will deliver a talk on "Treatment for Maxillofacial Trauma in Athletes," while William Heintz, D.D.S., also of Columbus, will speak on "Disturbing Recent Confusion and Concern: Update in Mouth Protection for Athletes."

On the subject of "Nutrition Relating to the Athlete," Luther B. Travis, M.D., of Galveston, Texas, will talk on "Effects of Exercise in Diabetes," and Richard A. Guthrie, M.D., of Wichita, Kansas, will speak on "Regulation of the Athlete With Diabetes."

Doctor Guthrie, who serves as Executive Director of the Kansas Regional Diabetes Education and Research Center, will direct his remarks to diabetes mellitus, a common disorder encountered in sports medicine. The problem, according to Doctor Guthrie, is doubly difficult since, unlike many diseases which are unaffected by exercise, activity greatly affects diabetes control, and diabetes control greatly affects the ability to exercise.

Properly managed, however, the athlete with diabetes mellitus should perform as well as the athlete without the disease, Doctor Guthrie concludes.

#### Nutrition and Exercise

Appearing on the same general session format with Doctors Guthrie and Travis will be Ralph Nelson, M.D., of Champaign, Illinois, who will discuss "Nutrition and the Athlete." Doctor Nelson, Professor of Nutrition at the University of Illinois School of Clinical Medicine, will address his remarks toward what he feels are misconceptions concerning nutrient requirements for exercise. An example he points out is the semi-starvation deliberately practiced by wrestlers who lose body weight, and the traditional use of high-calorie supplement to gain weight.

Mike Marshall, who pitched for the Los Angeles Dodgers and Minnesota Twins for more than 15 years, will appear at a 12-noon luncheon. His topic will be: "Trauma to the Adolescent Throwing Arm."

In the general session covering "Knee Pain and the Athlete," moderator Bernard R. Cahill, M.D., of Peoria, Illinois, will deliver a talk on "Who Gets Knee Pain and What Causes the Condition?" Also speaking at the session will be George D. Rovere, M.D., and Fred L. Allman, Jr., M.D.

Doctor Rovere, of Winston-Salem, North Carolina, will discuss "Diagnostic Aids in the Evaluation of Knee Pain," and Doctor Allman, of Atlanta, will talk on "The Treatment of Knee Pain."

Doctors Cahill, Rovere and Allman, who also will participate in a panel discussion, will be making presentations on behalf of the American Orthopedic Society for Sports Medicine.

Further information on the conference is available from the office of Jack Bell, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

## AMA Terms Noise Serious Health Problem

The world around us is often much too noisy.

Noise can be more than just an annoyance. It can cause emotional and physicial health problems — notably, deafness.

The recognition of noise as an environmental health problem has not received sufficient attention in this country, declares an American Medical Association booklet, "The Physician's Guide To Noise Pollution."

The AMA booklet calls for physicians to become knowledgeable about the medical consequences of excessive noise, support necessary legislation to reduce the problem, and promote effective and well-conceived programs aimed at noise control and prevention.

As far back as 1938, an article in the *Journal of the American Medical Association* noted that "the multiple and insidious ill effects of noise constitute an inadequately recognized, baneful influence on lives of millions of persons throughout the country."

And in the summer of 1980, the *Journal* once again hit at the noise hazard, pointing out that "The constant bombardment by noise is more than we were ever meant to hear."

## New Book On Sodium, Potassium Exposure In Food, Drugs

Consumers who want to reduce salt and total sodium intake may be handicapped by the absence of appropriate information on food labels.

This observation is one of several offered by L. J. Filer, Jr., M.D., Ph.D., of the University of Iowa College of Medicine, in a 78-page book, *Sodium and Potassium in Foods and Drugs*, published by the American Medical Association.

Edited by Philip L. White, Sc.D., and Stephanie C. Crocco, Ph.D., of the AMA Department of Foods and Nutrition, the book is designed to provide important information to physicians, dietitians and health professionals about current exposure to sodium and potassium as well as present food processing practices that employ the two minerals.

This publication, according to Doctor White and Crocco, "is current and the topic is timely." Considerable information is provided on sodium in foods and drugs to assist in patient education programs. This information has been compiled in a single reference useful to professionals and students in food, nutrition and medicine, they point out.

**Label Information Needed**

The AMA, in its recent comments to regulatory agencies, suggested that both sodium and potassium information on food labels would be of value.

"Should it become desirable to reduce sodium intake beyond the mere avoidance of table salt," Doctors White and Crocco report, "some technogical use of sodium-containing substances might have to be modified or abandoned."

Whatever specific recommendations are used, however, more must be known about the chemical content of available foods from which choices will be made. Salt cannot be eliminated entirely.

In the area dealing with the technology of sodium in fermented and processed foods, C. F. Niven, Jr., Ph.D., of the Del Monte Research Center, comments that "aside from its role in imparting the characteristic flavor, salt is a common and indispensable functional ingredient, whatever the nature of the fermented food."

In the chapter dealing with "Sodium Containing Additives in Processed Meats," J. L. Marsden, Ph.D., of Wilson Foods Company, asserts that recognition must be given to the fact that sodium-containing substances perform important technological functions.

# *Medical Meetings*

Dec. 4—Hyaline Membrane Disease (Outreach Program, WVU Medical Center/Charleston Division), Williamson.

Dec. 6—Arthritis Symposium (Arthritis Foundation, WV Chap.; WVU, CAMC), Charleston.

Dec. 6-11—Am. Academy of Dermatology, New York City.

**1981**

Jan. 14-16—Am. Diabetes Assn., Phoenix, Ariz.

**Jan. 23-25—14th Mid-Winter Clinical Conference, Charleston.**

Jan. 24—22nd. National Conference on Medical Aspects of Sports, Atlanta.

Jan. 24-26 — AMA Winter Scientific Meeting, Atlanta.

Jan. 28-31—2nd Mid Winter Cardiovascular Symposium (Am. Heart Assn., WV Affiliate; WVU, CAMC), Snowshoe Ski Resort, Slatyfork.

Feb. 1-4—Am. Hospital Assn., Washington, D. C.

Feb. 11-14—Am. College of Nuclear Physicians, New Orleans.

Feb. 15-19—Am. College of Psychiatrists, Tucson, Ariz.

Feb. 22-25—Southeastern Surgical Congress, New Orleans.

March 7-11—Am. Academy of Allergy, San Francisco.

March 8-12—Society of Head & Neck Surgeons; and Am. Society for Head & Neck Surgery, Phoenix, Ariz.

March 23-25—Am. Society of Abdominal Surgeons, Tampa, Fla.

March 23-27—Am. Roentgen Ray Society, San Francisco.

April 4—WV Branch #41, Am. Med. Woman's Assn., Huntington.

April 6-9—Am. College of Physicians, Kansas City, Mo.

April 8-11—Tenn. Med. Assn., Knoxville.

April 10-12—WV AAFP Scientific Assembly, Charleston.

April 15-16—WV Chap., Am. Academy of Pediatrics, Huntington.

April 22-30—Am. College of Obstetricians & Gynecologists, Las Vegas.

April 26-29—WV Academy of Ophthalmol. & Otolaryngol., White Sulphur Springs.

April 30-May 2—Am. Society of Clinical Oncology, Washington, D. C.

May 10-14—Am. Urological Assn., Boston.

May 16-20—Ohio State Med. Assn., Cleveland.

June 7-11—AMA House of Delegates, Chicago.

**Aug. 20-22—114th Annual Meeting, W. Va. State Medical Assn., White Sulphur Springs.**

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
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**Contraindications:** Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered, isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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# Alpha Stimulation

## Central Control of Blood Pressure*

*The Family of Man* by Roberto Moretti, a statuary in crystal symbolizing the broad range of hypertensive patients eligible for therapy with Catapres

# The Alpha Advantage:

## It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

| | |
|---|---|
| Congestive heart failure | Allergic rhinitis |
| Ventricular hypertrophy | Hepatic disease |
| Hyperglycemia | Hyperuricemia |
| Diabetes mellitus | Gouty arthritis |
| Bronchial asthma | Sulfonamide hypersensitivity |

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

**work/play**—normal hemodynamic responses to exercise maintained.

**love**—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

**cardiac output**—tends to return to control values during long-term therapy.

**blood flow**—preserved in kidney.

*No Single Advantage Determines Drug Choice.*

Other factors must include:

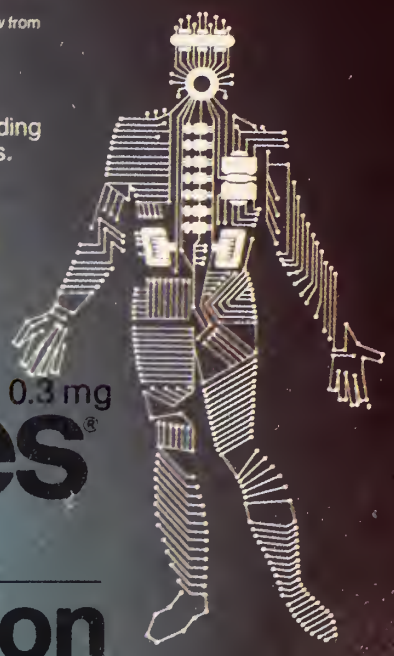
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Data: alpha-adrenergic stimulation decreases sympathetic outflow from the brain as shown in animal studies.

1 Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

**Now available in new 0.3 mg tablets**



Tablets of 0.1, 0.2, 0.3 mg

# Catapres®

(clonidine HCl)

# Hypertension

# The Alpha Advantage:

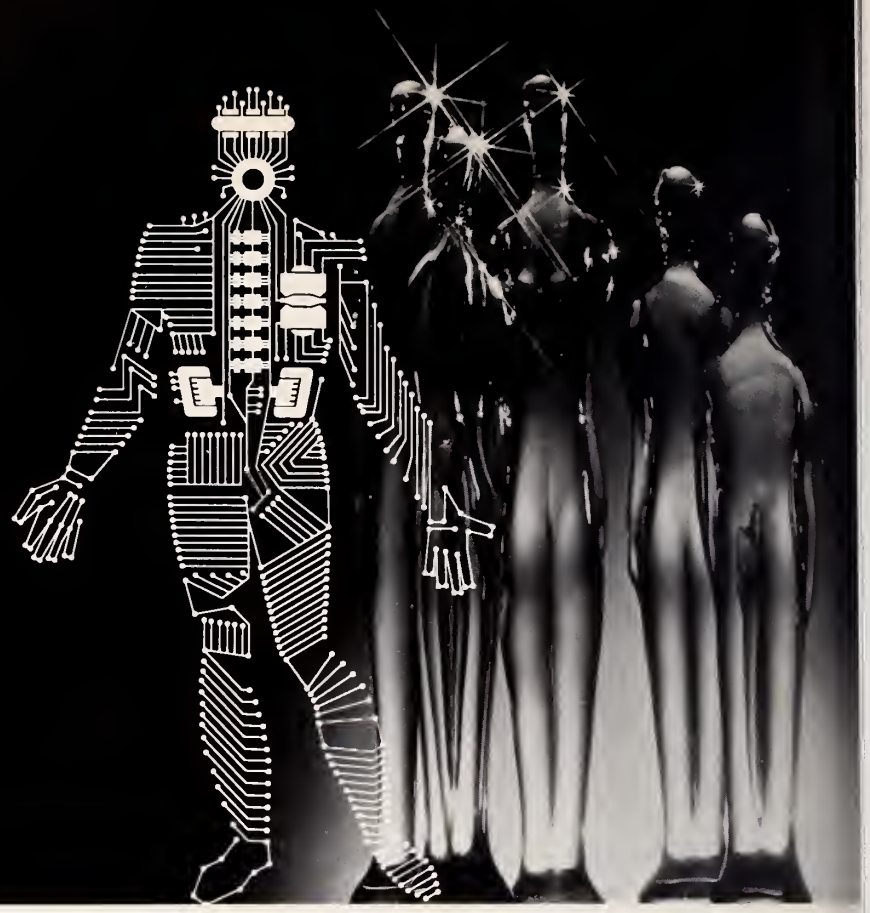
## It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

# Catapres®

(clonidine HCl)

## Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

---

**Catapres®**
**(clonidine hydrochloride)**
**Tablets of 0.1, 0.2, 0.3 mg**

**Indication:** The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

**Warnings:** Tolerance may develop in some patients necessitating a reevaluation of therapy.
*Usage in Pregnancy:* In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
*Usage in Children:* No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

**Precautions:** When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

**Adverse Reactions:** The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chlorthalidone and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

**Overdosage:** Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

**How Supplied:** Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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# The 14th Mid-Winter Clinical Conference

Holiday Inn Charleston House

600 Kanawha Boulevard, East, Charleston, W. Va.

**January 23-25, 1981**

**WEST VIRGINIA STATE MEDICAL ASSOCIATION**
**WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE**
**MARSHALL UNIVERSITY SCHOOL OF MEDICINE**

## WATCH THE JOURNAL FOR PROGRAM DETAILS

**THE PROGRAM CO-CHAIRMEN** again are Ralph H. Nestmann, M. D., and Joseph T. Skaggs, M. D., both of Charleston. Also on the Program Committee are William O. McMillan, Jr., M. D., of Charleston, Maurice A. Mufson, M. D., Huntington; Robert L. Smith, M. D., Morgantown, and C. Carl Tully, M. D., South Charleston.

**THE REGISTRATION FEE** of $40 for the entire conference will be charged all registrants except nurses, medical students, interns and residents. Advance registration is requested, and please make checks payable to "WEST VIRGINIA STATE MEDICAL ASSOCIATION."

**ACCREDITATION:** Attendance will be acceptable for 13 hours of Category 1 credit toward the Physician's Recognition Award of the American Medical Association; and the program also is acceptable for 13 Prescribed hours by the American Academy of Family Physicians.

**OVERNIGHT ACCOMMODATIONS:** Physicians should communicate directly with the reservation manager of the hotel or motor inn of their choice, with the conference headquarters hotel setting aside rooms for registrants.

**FOR ADVANCE REGISTRATION,** please complete the form below and mail to: WEST VIRGINIA STATE MEDICAL ASSOCIATION, P. O. BOX 1031, CHARLESTON, W. VA. 25324.

---

Please register me for the 14th Mid-Winter Clinical Conference in Charleston, W. Va., January 23-25, 1981. My $40 registration fee is (is not) enclosed.

*Name (please print)* _____ *Specialty* _____

*Address* _____ *City* _____

# WVU Medical Center
# –News–

*Compiled from material furnished by the Medical Center News Service, Morgantown, W. Va.*

## Tubing Speeds Up Return To Normal Speech

A one-inch length of silicone tubing is helping patients who have had their larynxes removed because of cancer regain more normal speech more quickly, according to a WVU Medical Center otolaryngologist.

Although use of the prosthesis, known as a duckbill speech tube (DST), is just beginning at University Hospital, Dr. Roger Anderson believes it holds great promise and has a number of advantages over previously developed appliances.

His enthusiasm is based on his experiences working with the developers of the DST, Drs. Mark I. Singer and Eric D. Blom at Indiana University. Doctor Anderson, an Instructor in the Department of Otolaryngology, recently spent three days at Indiana learning the surgical techniques for insertion of the prosthesis and procedure for postoperative care.

"It is less expensive to replace," he explained. "The surgery is only a 15-minute procedure. Patients can remove it for cleaning and reinsert it themselves. They are able to talk better with greater volume and quality and more complete sentences. They are able to use the telephone."

DST can accelerate learning while producing more normal, sustained sound because it makes available exhaled air from the lungs, Doctor Anderson added.

The tiny tube, a little more than an inch in length and less than one-fourth an inch in diameter, shunts exhaled air from the trachea to the esophagus. To accomplish this transfer, the patient has only to cover the tracheostoma with his hand.

The prosthesis takes its name from a razor-thin slit which resembles a duck's bill. This slit functions as a valve, allowing air to enter the esophagus, but preventing leakage of liquids into the trachea.

Surgery to install the tube is little more than an endoscopic procedure done under general anesthesia.

**During a program break at the recent sixth annual Hal Wanger Family Practice Conference at the West Virginia University Medical Center, Doctor Wanger's widow, Dr. S. Elizabeth McFetridge of Shepherdstown, talks with her sons, Dr. William H. Wanger of Beckley and Dr. H. Alexander Wanger of Martinsburg, from left, and Dr. John W. Traubert, Professor and Chairman of Family Practice in the WVU School of Medicine. The Family Practice Department and the Office of Continuing Medical Education at WVU and the West Virginia Chapter of the American Academy of Family Physicians sponsor the event.**

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# Third-Party News, Views and Program Concerns

## Widespread Sale Of DMSO Concerns FDA

The Food and Drug Administration recently expressed concern again about the widespread sale of DMSO (dimethyl sulfoxide) in certain parts of the United States, especially the Northwest.

In the Northwest, the agency said, products purporting to be DMSO are being sold on street corners, at smoke shops, and in gas stations and are being used by many people to treat arthritis. Reports of DMSO sales also have been received from other sections of the country.

DMSO is available as a degreaser, and the agency is concerned about the use of a substance of unknown purity and quality for medicinal purposes.

"The drug laws are intended to assure that the drugs we take are of the highest quality and purity, and are tested for safety and effectiveness before marketing," said James W. Swanson, FDA Regional Director in Seattle. "We do not know the purity or quality of the so-called DMSO that is being sold."

Swanson expressed particular concern about reports that some people may be injecting the substance being bought on street corners directly into their bodies. "This is indeed very risky business," he said.

"This is a situation in which FDA can best serve public health needs by warning about the danger to health. The street-corner type distribution is so widespread that legal action would be difficult and costly for the agency," he said. "FDA must seriously question whether it should use its limited resources in an attempt to protect those who intentionally misuse a product."

The FDA has received reports about chemical-irritation-type burns associated with concentrated DMSO used on skin or mucous membranes. Side effects associated with use of the drug in tests include nausea, headache and skin rash. Animal studies suggest DMSO can affect the eyes and cause loss of visual acuity or other adverse effects.

The FDA is interested in learning, either from DMSO users or their physicians, of any adverse effects resulting from use of the substances.

Many people started treating themselves with DMSO for arthritis, sprains, strains, and similar conditions following recent television reports about the drug. Human use of DMSO is approved by FDA only for treatment of a rare, painful bladder condition called chronic interstitial cystitis. There is insufficient evidence to show that the drug is either safe or effective in treating arthritis or bursitis. In animals, DMSO is approved as a topical treatment for horses and dogs to reduce acute swelling due to trauma.

## Medicare Reimbursement Sought For Nuclear Medicine Labs

The conditions that must be met by independent laboratories to qualify for Medicare reimbursement and other federal program funds unduly restrict the development and operation of nuclear medicine laboratories.

This was declared by the American Medical Association recently in comments submitted to the U. S. Department of Health and Human Services.

The qualification requirements of laboratory directors should be amended to include recognition of a physician's certification by the American Board of Nuclear Medicine, the AMA said. "The field of nuclear medicine has been a recognized specialty in the medical community since 1971, "the AMA pointed out. "The American Board of Nuclear Medicine is a conjoint board made up of representatives from the fields of internal medicine, pathology, and radiobiology . . . From the standpoint of federal reimbursement policy, the discrimination omitting recognition of nuclear medicine should be rectified," the AMA stated.

# PATHOLOGY ASSOCIATES LABORATORY

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**THOMAS S. LANAVA, M. D.**
**MEDICAL DIRECTORS**

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- Serology
- Immunohematology
- Microbiology
- Urinalysis
- Isotopes
- Venipuncture
- Consultation
- House Calls
- Histopathology
- Cytopathology

# Obituaries

## SANDERS G. DAVIDSON, M. D.

Dr. Sanders G. Davidson, Bluefield radiologist, died on September 22 in a hospital there. He was 78.

Doctor Davidson retired in 1969 after 35 years as a radiologist with the Bluefield Sanitarium Clinic. He practiced in Troutville, Virginia, from 1929-1935.

A native of Bluefield, Virginia, Doctor Davidson was certified by the American Board of Radiology.

He attended Roanoke (Virginia) College and received his M. D. degree in 1927 from the University of Virginia. He interned at Roanoke Hospital and took his residency at the University of Virginia.

Doctor Davidson was an honorary member of the Mercer County Medical Society, West Virginia State Medical Association and American Medical Association.

Surviving are the widow and one daughter, Mrs. J. Stephen Bethea III of Atlanta.

* * *

## JOSEPH E. ROBINS, JR., M. D.

Dr. Joseph E. Robins, Jr., of Urbanna, Virginia, formerly of Charleston, died on November 4 in a Charleston nursing home. He was 86.

A general practitioner, Doctor Robins retired in 1979. He moved to Urbanna in 1967.

He was a former member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Surviving are a daughter, Mrs. Patricia Bartlett of Charleston; a son, Joseph E. Robins III of Charleston; a sister, Mrs. Madge Littlepage of Milton, and a brother, Dr. Hugh B. Robins of Glenshaw, Pennsylvania.

* * *

## GROVER B. SWOYER, M. D.

Dr. Grover B. Swoyer of Point Pleasant, a pathologist, died on November 3 in a Charleston hospital. He was 58.

Doctor Swoyer was Director of Clinical Laboratories at Memorial Division, Charleston Area Medical Center, from 1958 to 1977, and

(Continued On Page xix)




**CYCLAPEN®-W** (cyclacillin)

**Indications**
*Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications:* Treatment of the following infections:
RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.
SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, nonpenicillinase producers.
URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)
NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

**Contraindications** Contraindicated in individuals with history of an allergic reaction to penicillins.

**Warnings Cyclacillin should only be prescribed for the indications listed herein.**

**Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.**

**Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.**

**Precautions** Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.
PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.
NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

**Adverse Reactions** Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.
As with other semisynthetic penicillins, SGOT elevations have been reported.
As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.
Cyclacillin is not indicated in children under 2 months of age.
*Patients with Renal Failure* Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).
**Dosage** (Give in equally spaced doses)

| INFECTION | ADULTS | CHILDREN* |
|---|---|---|
| *Respiratory Tract* | | |
| Tonsillitis & Pharyngitis | 250 mg q.i.d. | body weight < 20 kg (44 lbs) 125 mg q.i.d.<br>body weight > 20 kg (44 lbs) 250 mg q.i.d. |
| Bronchitis and Pneumonia | | |
| Mild or Moderate Infections | 250 mg q.i.d | 50 mg/kg/day q.i.d. |
| Chronic Infections | 500 mg q i.d. | 100 mg/kg/day q.i.d. |
| Otitis Media | 250 mg to 500 mg q.i.d † | 50 to 100 mg/kg/day† |
| Skin & Skin Structures | 250 mg to 500 mg q.i.d.† | 50 to 100 mg/kg/day† |
| Urinary Tract | 500 mg q.i.d. | 100 mg/kg/day |

*Dosage should not result in a dose higher than that for adults.
†depending on severity

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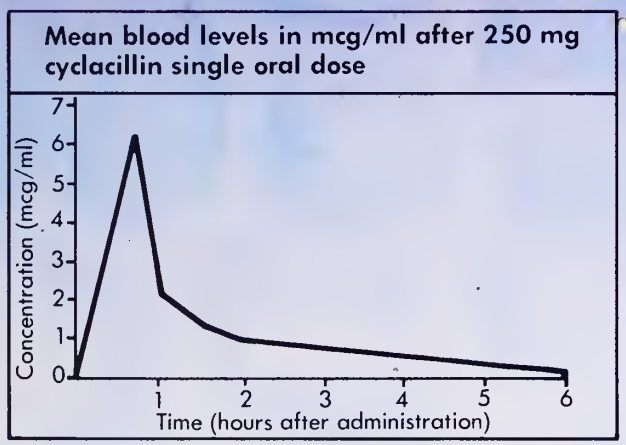


- Rapid, virtually complete absorption from GI tract
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- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on $T^{\alpha}$ ½ values for single oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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## Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

## Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

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(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

**more than just spectrum**

NEW NAME

# County Societies

## CENTRAL WEST VIRGINIA

The Central West Virginia Medical Society met on October 2 in Buckhannon at the Centennial Motel.

Dr. L. Walter Fix of Martinsburg, President of the State Medical Association, and Mrs. Fix were special guests.

Doctor Fix spoke on the concerns of the State Medical Association, including the current malpractice insurance situation.

Other guests included Charles R. Lewis of Charleston, Executive Secretary of the State Medical Association; Thomas Auman, also of Charleston, Account Supervisor for Aetna Life and Casualty, the malpractice insurance carrier for the State Medical Association, and Patton V. Nickell and Jeffrey S. Neal, West Virginia University medical students.

The Society voted to pay the State Medical Association dues of $15 for medical students at West Virginia University and Marshall University from the Central West Virginia Society area.—Joseph B. Reed, M. D., Secretary.

* * *

## HARRISON

The Harrison County Medical Society met on October 2 at the Sheraton Inn in Clarksburg.

The guest speaker was Dr. L. Blair Thrush of Morgantown, Assistant Professor of Medicine and Chief, Allergy Section, West Virginia University School of Medicine.—Carlos A. Naranjo, M. D., Secretary.

* * *

## McDOWELL

The McDowell County Medical Society met on October 8 at the home of Dr. Ross M. Patton of Gary.

Dr. L. Walter Fix of Martinsburg, President of the State Medical Association, was the guest speaker. His talk was extremely well received. —Muthusami Kuppusami, M. D., Secretary.

* * *

## LOGAN

The Logan County Medical Society met on October 8 at Logan General Hospital.

A film produced by the American Medical Association regarding current procedural termi-

(Continued On Page xix)

**OPENINGS**
**AT**
**THE MYERS CLINIC**
**Philippi, West Virginia**
**IN**
**Family Practice**
**Obstetrics and Gynecology**
**General Surgery**
**Ophthalmology**
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Fulvio Franyutti, M. D.

**Surgery:**
Hu C. Myers, M. D.
A. Kyle Bush, M. D.
J. W. Woodford, M. D.

**Gynecology and Obstetrics:**
Raymond W. Cronlund, M. D.

**Internal Medicine:**
E. G. Guy, M. D.
Karl J. Myers, Jr., M. D.
Wm. A. SanPablo, M. D.
C. S. Kadakia, M. D.

**Pediatrics:**
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Telephone: (304) 457-2800

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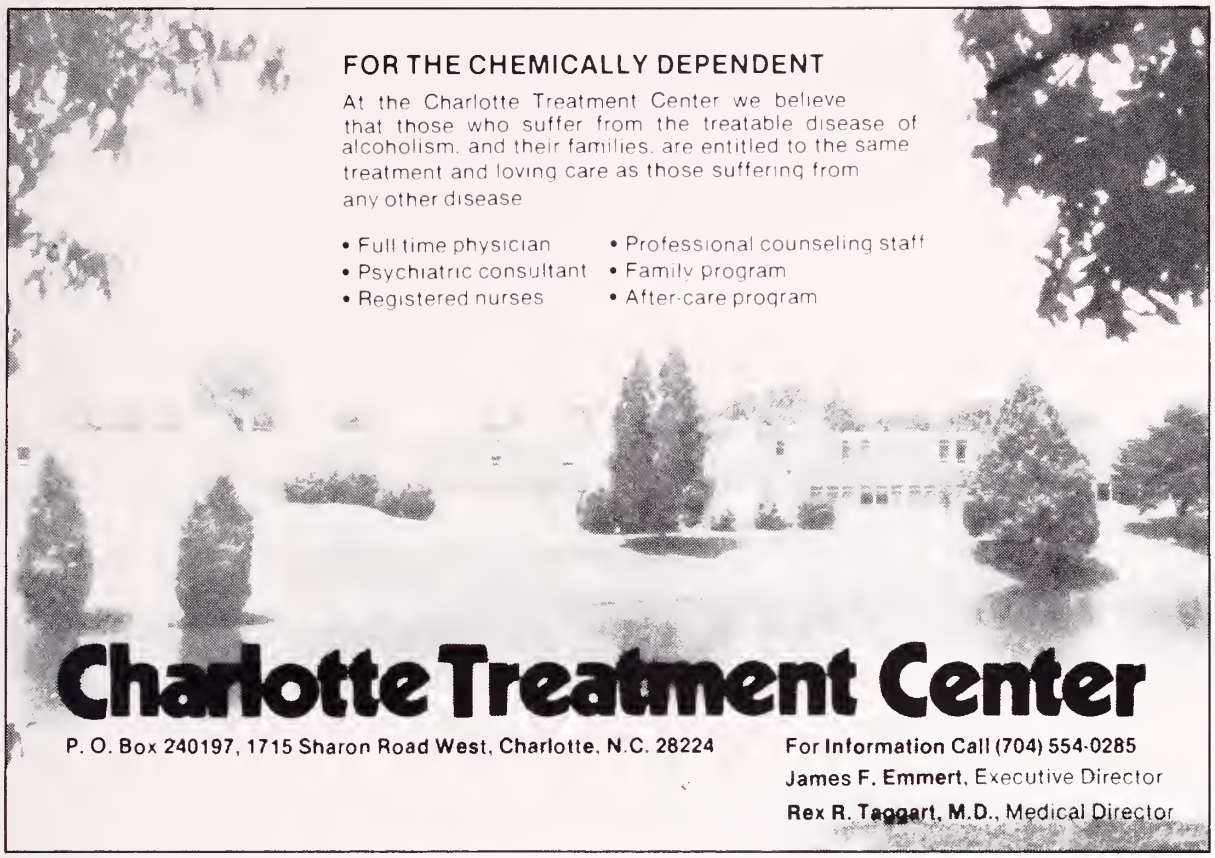


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had been on the staff of Pleasant Valley Hospital in Point Pleasant until this past October.

A native of Pittsburgh, he was graduated from Wittenberg University in Springfield, Ohio, and received his M. D. degree in 1946 from Ohio State University College of Medicine.

He interned at Allegheny General Hospital in Pittsburgh, and completed residencies there and at White Cross Hospital in Columbus, Ohio.

Doctor Swoyer, who served with the U. S. Army Medical Corps from 1947 to 1950, was a member of the Mason County Medical Society, West Virginia State Medical Association and American Medical Association.

Survivors include a daughter, Mrs. Mary Jo Annand of Alexandria, Virginia; a son, Grover B. Swoyer, Jr., of Morgantown; the mother, Mrs. Margaret B. Swoyer of Point Pleasant, and two sisters, Mrs. Rose Donaldson of Boston and Mrs. Rebekah Solinsky of Pittsburgh.

* * *

**JOHN C. CONDRY, M. D.**

Dr. John C. Condry of Venice, Florida, formerly of Charleston and Morgantown, died on October 27 in a Venice Hospital. He was 67.

A native of Clarksburg, Doctor Condry was a surgeon.

He was graduated from West Virginia University and received his M. D. degree in 1938 from the University of Louisville. He interned at St. Mary Hospital in Cincinnati, and completed residencies at Springfield (Ohio) City Hospital and Charleston General Hospital.

A World War II Army veteran, Doctor Condry was a Fellow of the American College of Surgeons and a Diplomate of the American Board of Surgery.

He was an honorary member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association, and a member of the International College of Surgeons.

Survivors include the widow; four sons, Dr. John C. Condry, Jr., of Ithaca, New York; Dr. Robert S. Condry of Chicago, Dr. Patrick J. Condry II of Morgantown, and Michael Condry, a student at Princeton University, Princeton New Jersey; two brothers, Joseph P. Condry of Charleston and Mark B. Condry of Parkersburg, and a sister, Mrs. Margaret Gressang of Charleston.



nology was shown. The film stressed the importance of the clarity and consistency of a standardized method of reporting medical procedures, with benefit to the physician, patient and third-party carriers.—Herbert D. Stern, M. D., Secretary-Treasurer.

* * *

**CABELL**

The Cabell County Medical Society met jointly with the Cabell County Bar Association on October 9 at the Holiday Inn Gateway in Barboursville.

The guest speaker was former Governor Arch A. Moore, Jr., candidate for re-election to that office. He gave a well-received speech consisting of his appraisal of the current state of West Virginia, pointing to areas in which he felt leadership had been inadequate.—Charles E. Turner, M. D., Secretary.

* * *

**MARION**

Dr. William A. Neal of Morgantown was the scientific speaker for the meeting of the Marion County Medical Society on October 28 in Fairmont General Hospital.

Doctor Neal is Associate Professor of Pediatrics and Chairman of Pediatric Cardiology at West Virginia University School of Medicine. His subject was cardiovascular disease in children.—William L. Mossburg, M. D., President.

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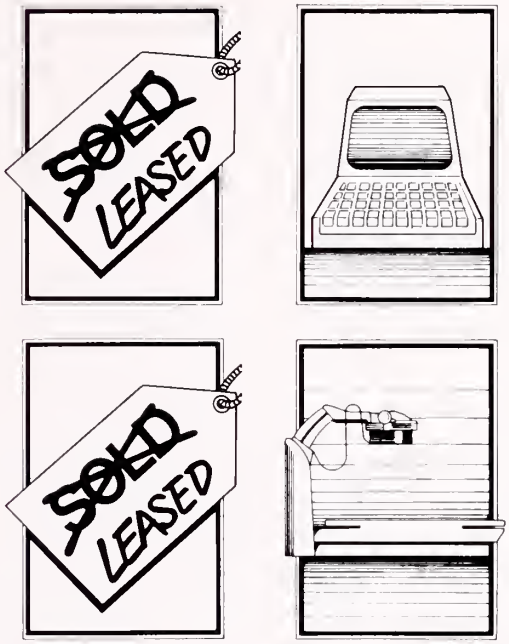


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# INDEX TO VOLUME LXXVI

## THE WEST VIRGINIA MEDICAL JOURNAL—1980


### A

Adenomacarcinoma, Concomitant Primary, of the Prostate, and Solitary Testicular Metastasis from Renal Cell Carcinoma—Gregory J. Post, M.D.; and Joseph Kassis, M.D. May 99

Anemia, Congenital Hypoplastic, Myelofibrosis-Polycythemia Syndrome on: A Case Report—Wilk O. West, M.D. June 134

Anido, Vicente, M.D.; Erlinda L. de la Pena, M.D.; and Cordell A. de la Pena, M.D.—Tuberculosis and Acute Leukemia July 159

Antidepressants, Not All Sadness Can Be Treated with—David M. Morgan, M.D. June 136

Anti-Inflammatory Drugs, Gastric Distress Evoked by—John C. Krantz, Jr., Ph.D. Feb. 37

Aortic Root, The Small—Robert A. Gustafson, M.D.; Alvin L. Watne, M.D.; William A. Neal, M.D.; and Thomas J. Tarnay, M.D. Sept. 225

Architect Designs A Needle, An—John C. Krantz, Jr., Ph.D. Apr. 84

Asbestos-Related Diseases of the Lung (Medical Grand Rounds from the West Virginia University Medical Center)—Edited by Irma H. Ullrich, M.D. July 163

Aspirin—Nothing Like It or Nothing Better—John C. Krantz, Jr., Ph.D. Sept. 231

Athlete, Adolescent, Sports Medicine and the—K. Douglas Bowers, Jr., M.D. Mar. 51

### B

Belis, John A., M.D.; and Bradford M. McCuskey, M.D.—Ureterocutaneous Fistula Following Nephrectomy Mar. 49

Bennett, John B., M.B.B.CH.; and John W. Durkin, Jr., M.D.—Ectopic Pregnancy Nov. 287

Biopsy, and Bone Marrow Aspiration—Peter C. Raich, M.D.; and John S. Rogers II, M.D. Jan. 1

Bladder, Inverted Papilloma of—Tara C. Sharma, M.D.; Harold N. Kagan, M.D.; John P. Sheils, M.D.; and Charles A. Hoffman, M.D. Nov. 285

Bladder, Metastatic Melanoma to the—Gregory J. Post, M.D.; and Bradford M. McCuskey, M.D. Jan. 7

Boerhaave's Syndrome, A Case of Recurrent—George F. Kish, M.D.; and Floyd A. Katske, M.D. Feb. 27

Bone Marrow Aspiration and Biopsy—Peter C. Raich, M.D.; and John S. Rogers II, M.D. Jan. 1

Bowers, K. Douglas, Jr., M.D.—Sports Medicine and the Adolescent Athlete Mar. 51

Boyd, J. Barry, M.D.; Ellen E. Hrabovsky, M.D.; and Alvin L. Watne, M.D.—Management of Gastroschisis Aug. 183

### C

Cancer, Breast, Management, Recent Advances in (Medical Grand Rounds from the West Virginia University Medical Center) — Edited by Irma H. Ullrich, M.D. Sept. 236

Carcinoma, Primary Squamous Cell, of the Endometrium: A Case Report— Chinmay K. Datta, M.D.; and Paul E. Gordon, M.D. May 109

Carcinoma, Renal Cell, Solitary Testicular Metastasis from, and Concomitant Primary Adenocarcinoma of the Prostate—Gregory J. Post, M.D.; and Joseph Kassis, M.D. May 99

Case of Recurrent Boerhaave's Syndrome, A—George F. Kish, M.D.; and Floyd A. Katske, M.D. Feb. 27

Causes of Perinatal Mortality in a Community Hospital: Report of a Prospective Study, 1975-1978—Narinder N. Sehgal, M.D. Nov. 291

Choriocarcinoma of the Lung, Primary: A Case Report—Ahmed H. Kalla, M.D.; Edward C. Voss, Jr., M.D.; and Robert J. Reed III, M.D. Oct. 261

Convocation, 1980 Student Research, West Virginia University School of Medicine Dec. 317

Cricco, Robert P., M.D.; Bradford M. McCuskey, M.D.; and Ahmed H. Kalla, M.D.—Epididymal Tumors: A Case Report Feb. 31

Cricco, R. P., M.D.; D. A. Lindert, M.D.; and B. M. McCuskey, M.D.—Urinoma Formation Secondary to Tumor Obstruction of the Ureter Dec. 311

### D

Datta, Chinmay K., M.D.; and Paul E. Gordon, M.D.—Primary Squamous Cell Carcinoma of the Endometrium: A Case Report May 109

de la Pena, Cordell A., M.D.; Vicente Anido, M.D.; and Erlinda L. de la Pena, M.D.—Tuberculosis and Acute Leukemia July 159

de la Pena, Erlinda L., M.D.; Cordell A. de la Pena, M.D.; and Vicente Anido, M.D.—Tuberculosis and Acute Leukemia July 159

Diagnosis and Treatment of Symptomatic Gastroesophageal Reflux (Medical Grand Rounds from the West Virginia University Medical Center)—Edited by Irma H. Ullrich, M.D. Nov. 295

Drugs, Anti-Inflammatory, Gastric Distress Evoked by—John C. Krantz, Jr., Ph.D. Feb. 37

Durkin, John W., Jr., M.D.; and John B. Bennett, M.B.B.CH.—Ectopic Pregnancy Nov. 287

Durkin, John W., M.D.—Pseudo-Eccyesis Dec. 315

### E

Ectopic Pregnancy—John W. Durkin, Jr., M.D.; and John B. Bennett, M.B.B.CH. Nov. 287

Elyaderani, Morteza E., M.D.; and Stanley J. Kandzari, M.D.—Percutaneous Antegrade Pyelography and Nephrostomy Guided by Ultrasound Jan. 5

Endometrium, Primary Squamous Cell Carcinoma of the: A Case Report—Chinmay K. Datta, M.D.; and Paul E. Gordon, M.D. May 109

Epididymal Tumors: A Case Report—Ahmed H. Kalla, M.D.; Robert P. Cricco, M.D.; and Bradford M. McCuskey, M.D. Feb. 31

### F

Fistula, Ureterocutaneous, Following Nephrectomy —John A. Belis, M.D.; and Bradford M. McCuskey, M.D. Mar. 49

Fractures, 342 Hip, Hospital Mortality in—Lance Matheny II; Thomas F. Scott, M.D.; Colin M. Craythorne, M.D.; Robert W. Lowe, M.D.; and John O. Mullen, M.D. Aug. 188

### G

Gastric Distress Evoked by Anti-Inflammatory Drugs—John C. Krantz, Jr., Ph.D. Feb. 37

Gastroschisis, Management of—J. Barry Boyd, M.D.; Ellen E. Hrabovsky, M.D.; and Alvin L. Watne, M.D. Aug. 183

Giustini, F. G., M.D.; D. Martinez, M.D.; and G. J. Mouhlas, M.D. — Pregnancy Following Jejunioileal Bypass June 130

Good Chances for Good Changes: Rehabilitation in West Virginia (Special Article)—Leslie F. McCoy, M.D. Apr. 86

Gordon, Paul E., M.D.; and Chinmay K. Datta, M.D.—Primary Squamous Cell Carcinoma of the Endometrium: A Case Report May 109

Grief, The Management of—William H. Nelson, M.D. Aug. 191

Gustafson, Robert A., M.D.; Alvin L. Watne, M.D.; William A. Neal, M.D.; and Thomas J. Tarnay, M.D.—The Small Aortic Root Sept. 225

## H


Hawley, H. Bradford, M.D.; Thomas A. Horsman, M.D.; William J. Zekan, M.D.; and Charles W. Stratton, M.D.—An Outbreak of Shigellosis in Kanawha County, West Virginia ... May 103

Hemostasis In Suprapubic Prostatectomy Utilizing Gelfoam Cone—Gregory J. Post, M.D.; and Joseph Kassis, M.D. ... Feb. 33

Hoffman, Charles A., M.D.; Tara C. Sharma, M.D.; Harold N. Kagan, M.D.; and John P. Sheils, M.D. —Inverted Papilloma of Bladder ... Nov. 285

Hoffman, Charles A., M.D.—The Human Factor (Special Article) ... Mar. 59

Horsman, Thomas A., M.D.; William J. Zekan, M.D.; Charles W. Stratton, M.D.; and H. Bradford Hawley, M.D.—An Outbreak of Shigellosis in Kanawha County, West Virginia ... May 103

Hospital Mortality in 342 Hip Fractures—Lance Matheny II; Thomas F. Scott, M.D.; Colin M. Craythorne, M.D.; Robert W. Lowe, M.D.; and John O. Mullen, M.D. ... Aug. 188

Howell, J. Harden III, M.D.; Philip M. Sprinkle, M.D.; and F. T. Sporck, M.D.—Laryngocele: A Review of the Literature and Case Report ... Apr. 75

Hrabovsky, Ellen E., M.D.; Alvin L. Watne, M.D.; and J. Barry Boyd, M.D. — Management of Gastroschisis ... Aug. 183

Human Factor, The (Special Article)—Charles A. Hoffman, M.D. ... Mar. 59


## I


Intensive Care Unit, Cost Effective?—A. H. Kalla, M.D.; and E. C. Voss, Jr., M.D. ... July 151

Inverted Papilloma of Bladder—Tara C. Sharma, M.D.; Harold N. Kagan, M.D.; John P. Sheils, M.D.; and Charles A. Hoffman, M.D. ... Nov. 285


## J


Jejunoileal Bypass, Pregnancy Following — D. Martinez, M.D.; G. J. Mouhlas, M.D.; and F. G. Giustini, M.D. ... June 130


## K


Kagan, Harold N., M.D.; John P. Sheils, M.D.; Charles A. Hoffman, M.D.; and Tara C. Sharma, M.D. — Inverted Papilloma of Bladder ... Nov. 285

Kalla, A. H., M.D.; and E. C. Voss, Jr., M.D.—Is Intensive Care Unit Cost Effective? ... July 151

Kalla, Ahmed H., M.D.; Edward C. Voss, Jr., M.D.; and Robert J. Reed III, M.D.—Primary Choriocarcinoma of the Lung, Primary ... Oct. 261

Kalla, Ahmed H., M.D.; Robert P. Cricco, M.D.; and Bradford M. McCuskey, M.D.—Epididymal Tumors: A Case Report ... Feb. 31

Kandzari, Stanley J., M.D.; and Morteza E. Elyaderani, M.D.—Percutaneous Antegrade Pyelography and Nephrostomy Guided by Ultrasound ... Jan. 5

Kassis, Joseph, M.D.; and Gregory J. Post, M.D.—Hemostasis In Suprapubic Prostatectomy Utilizing Gelfoam Cone ... Feb. 33

Kassis, Joseph, M.D.; and Gregory J. Post, M.D.—Solitary Testicular Metastasis from Renal Cell Carcinoma and Concomitant Primary Adenocarsinoma of the Prostate ... May 99

Katske, Floyd A., M.D.; and George F. Kish, M.D. —A Case of Recurrent Boerhaave's Syndrome ... Feb. 27

King, Halifax C., M.D.—Mass Lesions of the Neck ... Apr. 81

Kish, George F., M.D.; and Floyd A. Katske, M.D. —A Case of Recurrent Boerhaave's Syndrome ... Feb. 27

Krantz, John C., Jr., Ph.D.—An Architect Designs A Needle ... Apr. 84

Krantz, John C., Jr., Ph.D.—Aspirin—Nothing Like It or Nothing Better ... Sept. 231

Krantz, John C., Jr., Ph.D.—Gastric Distress Evoked by Anti-Inflammatory Drugs ... Feb. 37


## L


Laceration, Traumatic, of the Placenta—Firooz Ravangard, M.D.; and Charles V. Porter, M.D ... June 125

Laryngocele: A review of the Literature and Case Report—J. Harden Howell III, M.D.; Philip M. Sprinkle, M.D.; and F. T. Sporck, M.D. ... Apr. 75

Lesions, Mass, of the Neck—Halifax C. King, M.D. ... Apr. 81

Leukemia, Acute, and Tuberculosis—Erlinda L. de la Pena, M.D.; Cordell A. de la Pena, M.D.; and Vicente Anido, M.D. ... July 159

Leukemia, Acute, in Adults, The Treatment of—Brian K. Walker, M.D.; and Peter C. Raich, M.D. ... Oct. 257

Lindert, D. A., M.D.; B. M. McCuskey, M.D.; and R. P. Cricco, M.D.—Urinoma Formation Secondary to Tumor Obstruction of the Ureter ... Dec. 311

Lithium, A Review of (Medical Grand Rounds from the West Virginia University Medical Center)—Edited by Irma H. Ullrich, M.D. ... May 111

Lowe, Robert W., M.D.; John O. Mullen, M.D.; Lance Matheny II; Thomas F. Scott, M.D.; and Colin M. Craythorne, M.D.—Hospital Mortality in 342 Hip Fractures ... Aug. 188

Lung, Primary Choriocarcinoma of the: A Case Report—Ahmed H. Kalla, M.D.; Edward C. Voss, Jr., M.D.; and Robert J. Reed III, M.D. ... Oct. 261


## M


Management of Gastrochisis—J. Barry Boyd, M.D.; Ellen E. Hrabovsky, M.D.; and Alvin L. Watne, M.D. ... Aug. 183

Management of Grief, The—William H. Nelson, M.D. ... Aug. 191

Martinez, D., M.D.; G. J. Mouhlas, M.D.; and F. G. Giustini, M.D.—Pregnancy Following Jejunoileal Bypass ... June 130

Mass Lesions of the Neck—Halifax C. King, M.D. ... Apr. 81

Matheny, Lance II; Thomas F. Scott, M.D.; Colin M. Craythorne, M.D.; Robert W. Lowe, M.D.; and John O. Mullen, M.D.—Hospital Mortality in 342 Hip Fractures ... Aug. 188

McCoy, Leslie F., M.D.—Good Chances for Good Changes: Rehabilitation in West Vriginia (Special Article) ... Apr. 86

McCuskey, Bradford M., M.D.; Ahmed H. Kalla, M.D.; and Robert P. Cricco, M.D.—Epididymal Tumors: A Case Report ... Feb. 31

McCuskey, Bradford M., M.D.; and Gregory J. Post, M.D.—Metastatic Melanoma to the Bladder ... Jan. 7

McCuskey, Bradford M., M.D.; and John A. Belis, M.D.—Ureterocutaneous Fistula Following Nephrectomy ... Mar. 49

McCuskey, B. M., M.D.; R. P. Cricco, M.D.; and D. A. Lindert, M.D.—Urinoma Formation Secondary to Tumor Obstruction of the Ureter ... Dec. 311

Medical Discipline, Implications for: The New Medical Practice Act—William N. Walker, M.D.; and Patricia W. Williams, M.D. ... Sept. 233

Medical Practice Act, The New: Implications for Medical Discipline—William N. Walker, M.D.; and Patricia W. Williams, M.D. ... Sept. 233

Medical Grand Rounds from the West Virginia University Medical Center — Edited by Irma H. Ullrich, M.D.:

- Testicular Carcinoma ... Jan 9
- Mononucleosis Syndromes ... Mar. 54
- A Review of Lithium ... May 111
- Asbestos-Related Diseases of the Lung ... July 163
- Recent Advances in Breast Cancer Management ... Sept. 236
- Diagnosis and Treatment of Symptomatic Gastroesophageal Reflux ... Nov. 295

Melanoma, Metastatic, to the Bladder—Gregory J. Post, M.D.; and Bradford M McCuskey, M.D. ... Jan. 7

Metastatic Melanoma to the Bladder—Gregory J. Post, M.D.; and Bradford M. McCuskey, M.D. ... Jan. 7

Mononucleosis Syndromes (Medical Grand Grounds from the West Virginia University Medical Center)—Edited by Irma H. Ullrich, M.D. ... Mar. 54

Morgan, David M., M.D.—Not All Sadness Can Be Treated with Antidepressants ... Jan. 136

Mortality, Causes of Perinatal, in a Community Hospital: Report of a Prospective Study, 1975-1978—Narinder N. Sehgal, M.D. ... Nov. 291

Mouhlas, G. J., M.D.; F. G. Giustini, M.D.; and D. Martinez, M.D.—Pregnancy Following Jejunoileal Bypass ... June 130

Mullen, John O., M.D.; Lance Matheny II; Thomas F. Scott, M.D.; Colin M. Craythorne, M.D.; and Robert W. Lowe, M.D.—Hospital Mortality in 342 Hip Fractures ... Aug. 188

Myelofibrosis-Polycythemia Syndrome on Congenital Hypoplastic Anemia: A Case Report—Wilk O. West, M.D. ... June 134

## N


Neal, William A., M.D.; Thomas J. Tarnay, M.D.; Robert A. Gustafson, M.D.; and Alvin L. Watne, M.D.—The Small Aortic Root ... Sept. 225

Neck, Mass Lesions of the—Halifax C. King, M.D. Apr. 81

Nelson, William H., M.D.—The Management of Grief ... Aug. 191

Nephrostomy, Percutaneous Antegrade Pyelography and, Guided by Ultrasound—Morteza E. Elyaderani, M.D.; and Stanley J. Kandzari, M.D. ... Jan. 5

Nephrectomy, Ureterocutaneous Fistula Following —John A. Belis, M.D.; and Bradford M. McCuskey, M.D. ... Mar. 49

New Medical Practice Act, The: Implications for Medical Discipline—William N. Walker, M.D.; and Patricia W. Williams, M.D. ... Sept. 233

Not All Sadness Can Be Treated with Antidepressants—David M. Morgan, M.D. ... June 136


## O


Outbreak of Shigellosis in Kanawha County, West Virginia, An—Thomas A. Horsman, M.D.; William J. Zekan, M.D.; Charles W. Stratton, M.D.; and H. Bradford Hawley, M.D. ... May 103


## P


Papilloma, Inverted, of Bladder—Tara C. Sharma, M.D.; Harold N. Kagan, M.D.; John P. Sheils, M.D.; and Charles A. Hoffman, M.D. ... Nov. 285

Percutaneous Antegrade Pyelography and Nephrostomy Guided by Ultrasound—Morteza E. Elyaderani M.D.; and Stanley J. Kandzari, M.D. ... Jan. 5

Perinatal Mortality, Causes of, in a Community Hospital: Report of a Prospective Study, 1975-1978—Narinder N. Sehgal, M.D. ... Nov. 291

Placenta, Traumatic Laceration of the—Firooz Ravangard, M.D.; and Charles V. Porter, M.D. ... June 125

Porter, Charles V., M.D.; and Firooz Ravangard, M.D.—Traumatic Laceration of the Placenta ... June 125

Post, Gregroy J., M.D.; and Bradford M. McCuskey, M.D.—Metastatic Melanoma to the Bladder ... Jan. 7

Post, Gregory J., M.D.; and Joseph Kassis, M.D.—Hemostasis In Suprapubic Prostatectomy Utilizing Gelfoam Cone ... Feb. 33

Post, Gregory J., M.D.; and Joseph Kassis, M.D.—Solitary Testicular Metastasis from Renal Cell Carcinoma and Concomitant Primary Adenocarcinoma of the Prostate ... May 99

Pregnancy, Ectopic—John W. Durkin, Jr. M.D.; and John B. Bennett, M.B.B.CH. ... Nov. 287

Pregnancy Following Jejunoileal Bypass—D. Martinez, M.D.; G. J. Mouhlas, M.D.; and F. G. Giustinl, M.D. ... June 130

Presidential Address—Stephen D. Ward, M.D. ... Oct. 253

Primary Choriocarcinoma of the Lung: A Case Report—Ahmed H. Kalla, M.D.; Edward C. Voss, Jr., M.D.; and Robert J. Reed III, M.D. ... Oct. 261

Primary Squamous Cell Carcinoma of the Endometrium: A Case Report—Chinmay K. Datta, M.D.; and Paul E. Gordon, M.D. ... May 109

Prostate, Concomitant Primary Adenocarcinoma of the, and Solitary Testicular Metastasis from Renal Cell Carcinoma — Gregory J. Post, M.D.; and Joseph Kassis, M.D. ... May 99

Protatectomy, Hemostasis in Syprapubic, Utilizing Gelfoam Cone—Gregory J. Post, M.D.; and Joseph Kassis, M.D. ... Feb. 33

Pseudo-Eccyesis—John W. Durkin, Jr., M.D. ... Dec. 315

Pyelography and Nephrostomy, Percutaneous Antegrade, Guided by Ultrasound—Morteza E. Elyaderani, M.D.; and Stanley J. Kandzari, M.D. ... Jan. 5


## R


Raich, Peter C., M.D.; and Brian K. Walker, M.D.—The Treatment of Acute Leukemia in Adults ... Oct. 257

Raich, Peter C., M.D.; and John S. Rogers II, M.D. —Bone Marrow Aspiration and Biopsy ... Jan. 1

Ravangard, Firooz, M.D.; and Charles V. Porter, M.D.—Traumatic Laceration of the Placenta ... June 125

Reed, Robert J. III, M.D.; Ahmed H. Kalla, M.D.; and Edward C. Voss, Jr., M.D.—Primary Choriocarcinoma of the Lung: A Case Report ... Oct. 261

Rehabilitation in West Virginia: Good Chances for Good Changes (Special Article)—Leslie F. McCoy, M.D. ... Apr. 86

Rogers, John S. II, M.D.; and Peter C. Raich, M.D. —Bone Marrow Aspiration and Biopsy ... Jan. 1


## S


Scott, Thomas F., M.D.; Colin M. Craythorne, M.D.; Robert W. Lowe, M.D.; John O. Mullen, M.D.; and Lance Matheny II—Hospital Mortality in 342 Hip Fractures ... Aug. 188

Sehgal, Narinder N., M.D.—Causes of Perinatal Mortality in a Community Hospital: Report of a Prospective Study, 1975-1978 ... Nov. 291

Sharma, Tara C., M.D.; Harold N. Kagan, M.D.; John P. Sheils, M.D.; and Charles A. Hoffman, M.D.—Inverted Papilloma of Bladder ... Nov. 285

Sheils, John P., M.D.; Charles A. Hoffman, M.D.; Tara C. Sharma, M.D.; and Harold N. Kagan, M.D.—Inverted Papilloma of Bladder ... Nov. 285

Shigellosis, An Outbreak of, in Kanawha County, West Virginia—Thomas A. Horsman, M.D.; William J. Zekan, M.D.; Charles W. Stratton, M.D.; and H. Bradford Hawley, M.D. ... May 103

Small Aortic Root, The—Robert A. Gustafson, M.D.; Alvin L. Watne, M.D.; William A. Neal, M.D.; and Thomas J. Tarnay, M.D. ... Sept. 225

Solitary Testicular Metastasis from Renal Cell Carcinoma and Concomitant Primary Adenocarcinoma of the Prostate—Gregory J. Post, M.D.; and Joseph Kassis, M.D. ... May 99

Sporck, F. T., M.D.; J. Harden Howell III, M.D.; and Philip M. Sprinkle, M.D.—Laryngocele: A Review of the Literature and Case Report ... Apr. 75

Sports Medicine and the Adolescent Athlete—K. Douglas Bowers, Jr., M.D. ... Mar. 51

Sprinkle, Philip M., M.D.; F. T. Sporck, M.D.; and J. Harden Howell III, M.D.—Laryngocele: A Review of the Literature and Case Report ... Apr. 75

Stratton, Charles W., M.D.; H. Bradford Hawley, M.D.; Thomas A. Horsman, M.D.; and William J. Zekan, M.D.—An Outbreak of Shigellosis in Kanawha County, West Virginia ... May 103


## T


Tarnay, Thomas J., M.D.; Robert A. Gustafson, M.D.; Alvin L. Watne, M.D.; and William A. Neal, M.D.—The Small Aortic Root ... Sept. 225

Testicular Carcinoma (Medical Grand Rounds from West Virginia University Medical Center) — Edited by Irma H. Ullrich, M.D. ... Jan. 9

Traumatic Laceration of the Placenta—Firooz Ravangard, M.D.; and Charles V. Porter, M.D. ... June 125

Treatment of Acute Leukemia in Adults, The — Brian K. Walker, M.D.; and Peter C. Raich, M.D. Oct. 257

Tuberculosis and Acute Leukemia—Erlinda L. de la Pena, M. D.; Cordell A. de la Pena, M.D.; and Vicente Anido, M.D. ... July 159

Tumor Obstruction of the Ureter, Urinoma Formation Secondary to—R. P. Cricco, M.D.; D. A. Lindert, M.D.; and B. M. McCuskey, M.D. ... Dec. 311

Tumors, Epididymal: A Case Report—Ahmed H. Kalla, M.D.; Robert P. Cricco, M.D.; and Bradford M. McCuskey, M.D. ... Feb. 31


## U


Ullrich, Irma H., M.D. (Edited by)—Medical Grand Rounds from the West Virginia University Medical Center:

- Testicular Carcinoma ... Jan. 9
- Mononucleosis Syndromes ... Mar. 54
- A Review of Lithium ... May 111
- Asbestos-Related Diseases of the Lung ... July 163
- Recent Advances in Breast Cancer Management ... Sept. 236
- Diagnosis and Treatment of Symptomatic Gastroesophageal Reflux ... Nov. 295

Ureter, Urinoma Formation Secondary to Tumor Obstruction of the—R. P. Cricco, M.D.; D. A. Lindert, M.D.; and B. M. McCuskey, M.D. ... Dec. 311

Ureterocutaneous Fistula Following Nephrectomy—John A. Belis, M.D.; and Bradford M. McCuskey, M.D. ... Mar. 49

Urinoma Formation Secondary to Tumor Obstruction of the Ureter—R. P. Cricco, M.D.; D. A. Lindert, M.D.; and B. M. McCuskey, M.D. Dec. 311

V

Voss, E. C., Jr., M.D.; and A. H. Kalla, M.D.—Is Intensive Care Unit Cost Effective? July 151

Voss, Edward C., Jr., M.D.; Robert J. Reed, III, M.D.; and Ahmed H. Kalla, M.D.—Primary Choriocarcinoma of the Lung Oct. 261

W

Walker, Brian K., M.D.; and Peter C. Raich, M.D.—The Treatment of Acute Leukemia in Adults Oct. 257

Walker, William N., M.D.; and Patricia W. Williams, M.D.—The New Medical Practice Act: Implications for Medical Discipline Sept. 233

Ward, Stephen D., M.D.—Presidential Address Oct. 253

Watne, Alvin L., M.D.; J. Barry Boyd, M.D.; and Ellen E. Hrabovsky, M.D.—Management of Gastroschisis Aug. 183

Watne, Alvin L., M.D.; William A. Neal, M.D.; Thomas J. Tarnay, M.D.; and Robert A. Gustafson, M.D.—The Small Aortic Root Sept. 225

West Virginia University School of Medicine, 1980 Student Research Convocation Dec. 317

West, Wilk O., M.D. — Myelofibrosis-Polycythemia Syndrome on Congenital Hypoplastic Anemia: A Case Report June 134

Williams, Patricia W., M.D.; and William N. Walker, M.D.—The New Medical Practice Act: Implications for Medical Discipline Sept. 233

Z

Zekan, William J., M.D.; Charles W. Stratton, M.D.; H. Bradford Hawley, M.D.; and Thomas A. Horsman, M.D.—An Outbreak of Shigellosis in Kanawha County, West Virginia May 103

## CHANGE OF ADDRESS

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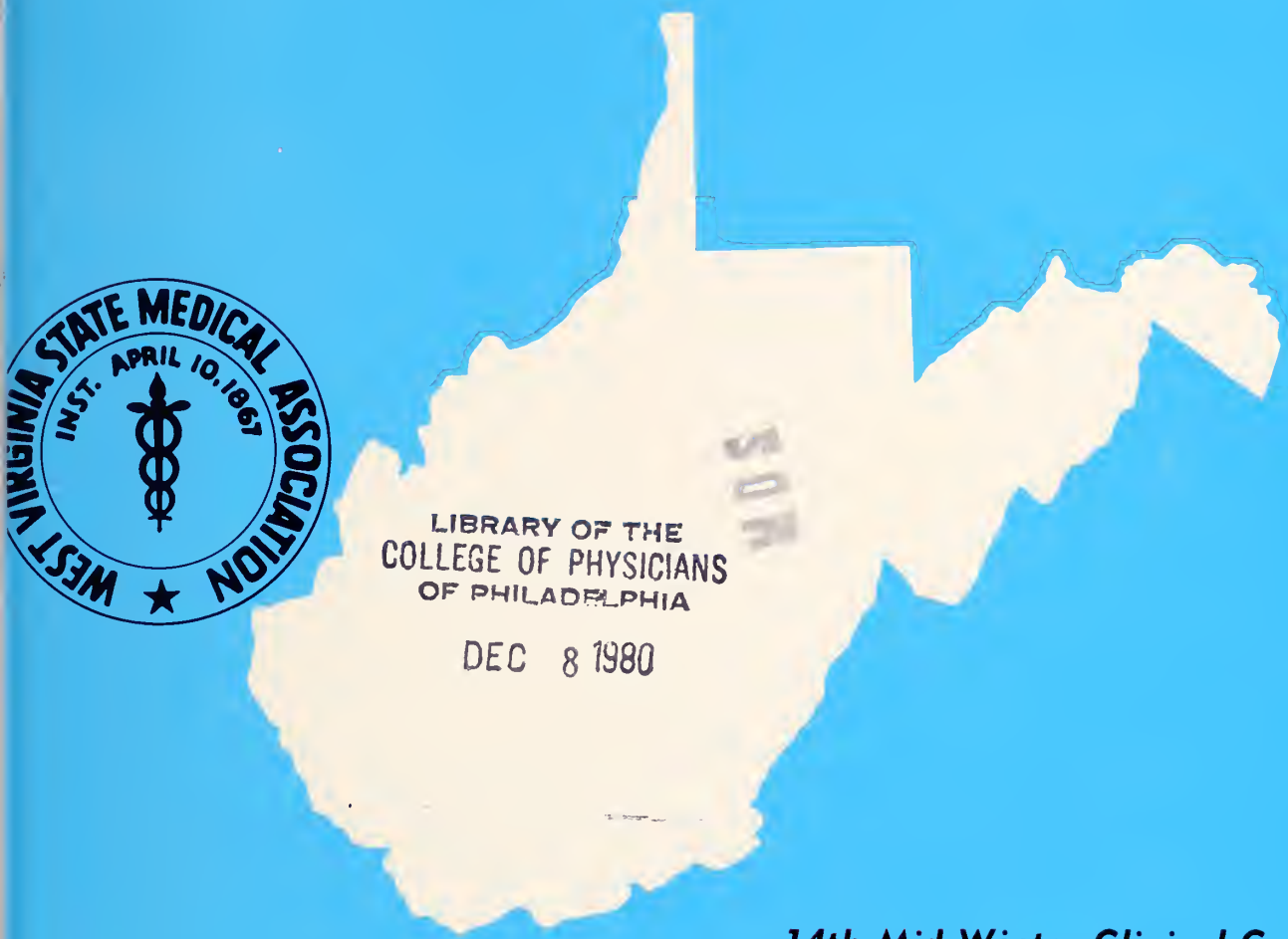


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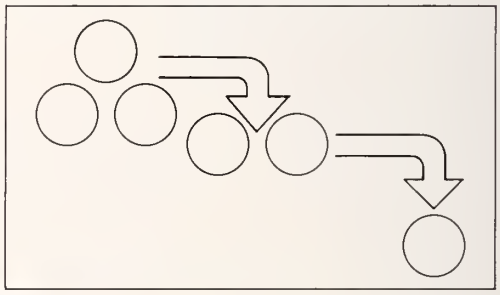

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**Warnings:** Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

**Precautions:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

**Adverse Reactions:** All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

**Dosage: Not recommended for infants less than two months of age.**

*Urinary Tract Infections:* Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

*Children two months of age or older*

| Weight | | Dose—every 12 hours | |
|---|---|---|---|
| lbs | kgs | Teaspoonfuls | Tablets |
| 20 | 9 | 1 teasp. (5 ml) | ½ tablet |
| 40 | 18 | 2 teasp. (10 ml) | 1 tablet |
| 60 | 27 | 3 teasp. (15 ml) | 1½ tablets |
| 80 | 36 | 4 teasp. (20 ml) | 2 tablets or 1 DS tablet |

For patients with renal impairment:

| Creatinine Clearance (ml/min) | Recommended Dosage Regimen |
|---|---|
| Above 30 | Usual standard regimen |
| 15-30 | ½ the usual regimen |
| Below 15 | Use not recommended |

*Pneumocystis carinii pneumonitis:* Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

**Supplied:** *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

**Please see back cover.**

Her next attack of cystitis may require

# the Bactrim™ 3-system counterattack

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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introita colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

## Bactrim fights uropathogens in the urinary tract/vaginal tract/lower intestinal tract

Please see reverse side for summary of product information.

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